



Being well and staying competent: *Challenges for the Surgeon*

The Governor's Committee on Physician Competency and Health has prepared this document for the purpose of providing education and resources about some of the challenges faced by surgeons in practice. While no document can be all-encompassing, we believe that the information and references provided will be of benefit and have created this for the use and well-being of our colleagues.

Created 2012

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I. Introduction and Implications

As surgeons, although we may be experts in promoting health in our patients, all too often we fail to prioritize our own health or that of our colleagues. We may not recognize or know how to address the issues that threaten our wellbeing and ultimately that of our patients. We understand that competence is “the ability to do something well, measured against a standard, especially ability acquired through experience or training”, yet may not realize that impairment can occur on a short-term or long-term basis. Competence is an essential part of our professional identities as well as a fundamental part of our relationship with patients. When faced with circumstances that interfere with this, our responses may range from anger to denial to blaming others – or we may simply be unaware of the loss of capabilities. Additionally, it is likely that at some time we will be interacting with a colleague or department member who appears to be struggling with these issues, or addressing this from a leadership position.

Being well also means more than “just getting through the day”. Unfortunately, for many of us, this attitude has become the norm. In a 2008 survey of Fellows of the American College, with nearly 8,000 respondents, nearly 40% gave answers consistent with burnout. A significant number of surgeons are experiencing depression and nearly 15% had considered suicide in the 12 months prior to the survey. Many of the personal traits we value as surgeons (commitment to patients and practice, a highly developed sense of responsibility, perfectionism) also predispose us to burnout. Many of the factors inherent in surgical practice also contribute: stress, less than ideal outcomes, trying to achieve work-home balance, factors that can’t be controlled, increasing demands on time as well as financial pressures in an uncertain economic and legislative climate.

Our goal in preparing this manual is to educate and inform our colleagues – as well as increasing awareness of available resources to address these concerns. Additionally, we hope to provide a reference to assist in dealing with issues and challenges for credentialing groups. Most of the committee members are not experts in these areas but all of us are surgeons who know and understand from experience the demands involved in being a surgeon. We also benefit from the professional expertise of several members who have both knowledge and experience at the national level.

By its nature, a document like this cannot be all-inclusive, nor do we profess that it is. The critical emphases are:

- You are not alone; other surgeons have experienced the same stresses, crises and situations
- Support and resources are available and we urge you to use them. The analytical tools included in this document are not intended to provide an absolute diagnosis – but to indicate that there may be an issue
- Talk to a colleague, access a website, contact the physician’s assistance program at your hospital or the physician health program in your state.

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II. Physician Personalities, Stress and Burnout

Mick Oreskovich and Jim Anderson

The practice of medicine is rapidly changing and causing significant stress for American physicians. This is particularly true for practicing surgeons. Examples of these stressors include: the loss of autonomy associated with hospital-based practice, the restrictions on practice associated with managed care, the ongoing escalation of malpractice lawsuits, and the maintenance of competency in a rapidly changing specialty. These stressors can interact with pre-existing psychological characteristics typical of surgeons to pose certain occupational hazards. As an example, society's expectation of perfection in surgical practice can become the surgeon's personal poison where he or she is haunted by their failures. Surgeons are trained to never make mistakes but when they occur the surgeon may be tormented by his or her own perfectionism resulting in self-incrimination, lack of acceptance and forgiveness, and even self-loathing. The compulsiveness, self-doubt, guilt, and exaggerated sense of responsibility add additional stress to an already difficult situation. The characteristics of the truly exceptional surgeon which include conscientiousness, ingenuity, self-sacrifice, and delay gratification are difficult to maintain in the face of an increasingly demanding environment.

Unfortunately, perfectionism is maladaptive. The "perfect" surgeon is unable to differentiate the wish to excel from the desire to be perfect. Numerous authors have demonstrated that perfectionism is the vulnerability factor for depression, anxiety, burnout, suicide (Beevers and Miller 2004; Flett and Hewitt 2002; Hamilton and Schweitzer 2000). The perfectionist often suffers from numerous cognitive distortions: that others value us only for our perfectionism; that the better we do the better we are expected to do; and that, if we lose the "edge" we will lose the support of our colleagues. The consequences of this perfectionism include the following: satisfaction with achievements is often short-lived; there is a sense of fraudulence when recognized with an award; and the drive isn't linked to desire for pleasure but rather to gain relief from the tormented psyche.

Perfectionism is one of the major precursors for burnout because it is often accompanied by an exaggerated sense of responsibility that leads to self-doubt and guilt which then leads to rigidity, stubbornness, and inability to delegate leading to devotion and identification with work to the exclusion of relationships and self-care. Perfectionism is also one of the predisposing factors for suicide because fear of failure provokes the need for omnipotence (we are personally responsible for *everything* that happens to our patients). The impending death of the patient generates existential anxiety regarding our powerlessness to stop death and the inability to control the final course of events leads us to a sense of futility about our lives and the lives of others. Perfectionism is one of the strongest precursors for burnout. Burnout is characterized by:

1. *Overwhelming physical and emotional exhaustion*
2. *Feelings of cynicism and detachment from the job*
3. *A sense of ineffectiveness and lack of accomplishment*
4. *Over-identification with work to the exclusion of other activities*
5. *Irritability and hypervigilance*

(Adapted from Kearney MK. Self-Care of Physicians Caring for Patients at the End Of Life. JAMA. 2009; 301:1155-1164).

This then leads to sleep problems, including nightmares, social withdrawal, poor judgment, professional and personal boundary violations, further perfectionism and rigidity, interpersonal conflicts, numbness and



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detachment, and difficulty in concentrating (*Adapted from Kearney MK. Self-Care of Physicians Caring for Patients at the End Of Life. JAMA. 2009;301:1155-1164*).

The Board of Governors Committee on Physician Competency and Health has performed two surveys of Fellows of the American College of Surgeons (2008, 2010) that have demonstrated a very strong association of burnout with quality of life and practice, depression, suicidal ideation, medical errors, and alcohol abuse.

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These publications from the Board of Governors Committee on Physician Competency and Health demonstrate a strong association between burnout and depression, suicidal ideation, decreased professional quality of life, decreased personal quality of life, medical errors, and alcohol abuse and dependence. In fact, burnout may be the prodrome for all of these conditions. Having said that, burnout is a reversible condition and a number of tools are available to both decrease and reverse burnout:

1. Promoting a culture of medicine that values work-life balance
2. Surgeons having access to online self-assessment tools to identify levels of stress and burnout
3. Promote the “just culture” paradigm during training and not tolerating shaming and humiliation
4. Defining our psycho-social-spiritual support system and accessing it readily and frequently
5. Identify our power vs. powerlessness over people, places, things and situations
6. Identify connection vs. disconnection
7. Identify self-knowledge vs. self-awareness
8. Developing educational programs that promote supportive environments
9. Most importantly, give ourselves permission to be sick and to accept good medical care

Lee Lipsenthal described the following keys to a balanced life in 2007:

1. Take care of ourselves so that we can take care of others
2. Our state of wellbeing affects our patient outcomes
3. Our personalities contribute greatly to our wellbeing
4. Our perception creates the world we live in
5. We have the power to change these things, we must want to
6. Developing gratitude, healthy boundaries and releasing a need for control are the best weapons against burnout

Finally, the ACS Governor’s Committee on Physician Competency and Health recommends answering each of these 15 questions regarding practices that are known to be preventative for burnout:

1. I find meaning in my work
2. I protect time away from work with my spouse, family and friends
3. I focus on what is most important to me in life
4. I try to take a positive outlook on things
5. I take vacations
6. I participate in recreation/hobbies/exercise
7. I talk with family, significant other, or friends about how I am feeling
8. I have developed an approach/philosophy to dealing with patients’ suffering and death
9. I incorporate a life philosophy stressing balance in my personal and professional life
10. I look forward to retirement
11. I discuss stressful aspects of work with colleagues
12. I nurture the religious/spiritual aspects of myself



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13. I am involved in non-patient care activities (e.g., research, education, administration)
14. I engage in contemplative practices or other mindfulness activities such as meditation, or narrative medicine
15. I engage in reflective writing or other journaling technique

The more positive the responses, the less likely we are suffering from burnout, depression, suicidal ideation, decreased professional quality of life, decreased personal quality of life, and abuse of alcohol or letter other drugs!

RESOURCES:

1. [The Physician as Patient: A Clinical Handbook for Mental Health Professionals](#) by [Michael F. Myers](#) and [Glen O. Gabbard](#) American Psychiatric Publishing, Inc. (Jan 15, 2008) ISBN -13: 978-1585623129
2. [Finding Balance in a Medical Life](#) by Lee Lipsenthal (Sep 1, 2007) ISBN-13: 978-0978532116
3. [Shame and Grace: Healing the Shame We Don't Deserve](#) by [Lewis B. Smedes](#) HarperOne (May 7, 1994) ISBN-13: 978-0060675226
4. [Spiritual Evolution: How We Are Wired for Faith, Hope, and Love](#) by [George E. Vaillant](#) Three Rivers Press; Reprint edition (June 9, 2009) ISBN-13: 978-0767926584
5. [Peace Is Every Step: The Path of Mindfulness in Everyday Life](#) by [Thich Nhat Hanh](#), Arnold Kotler and H. H. the Dalai Lama Bantam (March 1, 1992) ISBN-13: 978-0553351392
6. [The Art of Serenity: The Path to a Joyful Life in the Best and Worst of Times 1st edition](#) by [Karasu, T. Byram](#) Simon & Schuster Hardcover (Dec 24, 2002) ISBN-13: 978-0743228312



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III. Substance Abuse

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Summary:

- Surgeons are vulnerable to alcohol and substance abuse
- Rates of abuse are similar to general population.
- “Burn out” increases risk.
- Potential for patient harm, loss of credentials/licensure, personal/family costs.
- With treatment, better outcomes than general population.

Examples:

1. In the male surgeons’ locker room, someone is slumped over in one of the bathroom stalls. The stall door is locked and the person is unresponsive. A physician crawls underneath, opening the stall door and finds a colleague in the stall pale and unresponsive. There is a tourniquet on his arm, and blood and a syringe on the floor. The medical response team is called, but there is difficulty getting the stretcher into the bathroom. Cardiopulmonary resuscitation is begun. Although the patient appears to be blue as he is wheeled out of the bathroom, he eventually recovers completely. He enters a substance abuse program, and is subsequently able to return to the practice of anesthesiology.

2. A surgeon comes to the operating room to perform an emergency operation on the weekend. He is argumentative with the operating room staff, and he smells of alcohol. The charge nurse refuses to allow the surgeon to perform the case, insisting that one of his partners come in to perform the surgery. The surgeon is suspended until he is referred and successfully completes an alcohol abuse program. He successfully completes the program and eventually has his privileges restored.

Scope of the Problem:

- Surgeons are vulnerable to alcohol and drug abuse.

These are real life experiences. Unfortunately, there are many others which could have been used to illustrate the problems of alcohol and drug abuse among physicians, including the life of Dr. William Stewart Halsted. Although these vignettes may appear extreme to some, they illustrate the fact that most physicians who abuse alcohol or drugs do not refer themselves to treatment programs. A crisis is what usually precipitates referral. Physicians tend to have a sense of invulnerability, believing that they are in control, could quit at any time and that there is minimal risk. Yet, physicians are far from immune from the dangers of alcohol and drug abuse. The data are sparse regarding the incidence and prevalence of alcohol and drug abuse amongst physicians. Available data suggests the prevalence of alcohol and drug abuse among physicians is probably similar to that of the general population (1). Abuse of prescription medications, however, may be more prevalent among physicians and related to ease of access.

- Rates of abuse similar to general population.

Approximately 10 to 15% of health care professionals will misuse drugs or alcohol at some time during their career. Estimates are that 6 to 8% of physicians have substance abuse disorders and 14% alcohol abuse disorders. Substance abuse is higher in men than in women, both among healthcare providers and the general population.

- Often begins early; specialty differences.

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Substance abuse may begin early during medical school and residency for many physicians. Among medical students, drugs and alcohol are used mostly for recreational purposes. The pattern and prevalence of alcohol dependence among medical students is consistent with their age mates in the general population (2). As medical students progress through residency, the incidence of drug and alcohol consumption may actually decrease. It is estimated that substance abuse disorders in residents occur in between 10 and 14%. There are also differences by residency specialty. Emergency medicine residents and psychiatry residents showed the highest rates of substance abuse, most commonly marijuana or benzodiazepines. Access to narcotics increases vulnerability for anesthesiologists. Of interest to surgeons, surgical residents have the lowest rate of substance abuse, except for alcohol use (3). Later in their career, residents and attending physicians may abuse drugs for self treatment or for performance enhancement.

- Differences between male and female physicians.

Many differences have been noted between women and men physicians who abuse alcohol and drugs. A study of 969 impaired physicians enrolled in one of four state physician health programs revealed that female impaired physicians tend to be younger (39.9 vs. 43.7 years), and had more medical (48.7% vs. 34.4%) and psychiatric (76.5% vs. 63.9%) problems at the time of intake. Female impaired physicians were more likely to report past or current suicidal ideation, and more likely to have made a suicide attempt with or without the added influence of a substance. Though alcohol was the primary drug of abuse for all physicians studied, women physician were more likely to abuse sedative hypnotics than men. There were no gender differences in employment problems or legal problems (4). Another study confirmed higher rates of medical comorbidities among females rather than males with substance abuse disorders (5)

In addition to differences between male and female physicians, there are also differences among specialties and practice type. There appear to be higher rates of drug and alcohol abuse in emergency room physicians, psychiatrists, and physicians in solo practice.

- Results of ACS 2010 survey.

Information from the American College of Surgeons 2010 survey has recently become available. Of the 7,197 surgeons completing this survey, 15.4% had an Audit C score consistent with alcohol abuse or dependence. The rate of alcohol abuse or dependence was higher in women surgeons (25.6%) than in male surgeons (13%). Surgeons who were burnt out, depressed, or who reported a major medical error in the prior 3 months were more likely to have alcohol abuse or dependence. This illustrates that alcohol abuse and dependence is a major problem among American surgeons. (6)

The Surgeon at Risk:

- The surgical personality increases risk.

Similar to the general population, many physicians and medical students with substance abuse problems report a family history of substance abuse. Other contributing factors include stress at work, at home, emotional problems and sensation seeking behavior (3)

Physicians on the whole, tend to be idealistic and perfectionists as well as high academic achievers. All of these factors have been associated as risk factors for substance abuse. As we consider surgeons and the types of personalities and behaviors that are encouraged – and encourage success in the field – many of these may play a role. This personality type may make physicians more susceptible or prone to abuse of alcohol and drugs. Personality traits such as obsessive compulsive disorder may lead to success in medicine but may also predispose physicians to impairment. Indeed it has been shown that substance abuse has early roots, and a healthcare professional's underlying personality or behavior disorder may be unmasked by the stress of his or her chosen

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occupation. Physicians with substance abuse disorders have more personal and family childhood problems even before entering medical school (7).

The dependence and abuse often begins gradually. Alcohol is used in social settings, although, over time as clinical and interpersonal demands increase, its use may also increase. Then, as clinical responsibilities as well as other demands continue to accumulate, a simple “drink at the end of the day” becomes two then three then more. The escalation is often so gradual – and the thought is that it will be temporary “just until I get over” whatever the current crisis might be so powerful - that the individual becomes dependent without realizing it.

Identification of the Problem:

- Difficult to identify; denial and avoidance are common.

There are a variety of professions and occupations which require random mandatory drug testing including commercial airline pilots, transit workers, train operators, police officers, and the military. Random mandatory drug testing is not required of physicians and identifying physicians that abuse alcohol and drugs can be very difficult. They may feel that they are immune to developing a substance abuse disorder. Surgeons are accustomed to being in control and with “toughing things out” Most impaired physicians are in denial that they have a problem and because of a very deeply ingrained sense of responsibility, (8) clinically-related activities are often maintained even though all other aspects of an individual’s life are collapsing Physicians often tend to self diagnose and treat themselves without seeking help of their colleagues. Finally, physicians seem to be very adept at hiding signs and symptoms of substance abuse.

When problems surface, they are often manifested by family conflicts and marital strife. A decrease in clinical performance is usually one of the last overt signs of a substance abuse disorder (9) 10. Indeed by the time a decline in clinical performances is noted, the disorder is generally quite advanced. Signs and symptoms of substance abuse include frequent absence from work without reasonable explanations, consistent late arrival and missed appointments with patients, inaccessibility, inappropriate behavior, conflicts with colleagues, staff, and patients, rounding at odd hours, inappropriate orders, disorganized scheduling and missed deadlines, drinking heavily at hospital functions, multiple prescriptions for family members, long lunches or unnecessary breaks, and decrease chart and work performance (3) . The impaired physician may exhibit mood swings, personality changes, a tendency to be manipulative, and a lack of self discipline. Communications may be strained and associated with withdrawal from family and social activities, defensiveness, apathy, anxious behavior, There may be changes in longstanding friendships and relationships (3) Physical changes, such as weight loss or gain, poor physical condition, change in appearance and personal hygiene, altered in speech patterns, constantly dilated pupils, bloodshot or watery eyes, dizzy spells, stumbling and other findings are common manifestations of substance abuse(3)).

Consequences of Alcohol and Substance Abuse:

- Enormous consequences.

The consequences of physician alcohol and substance abuse are enormous. First and foremost is the potential for patient harm. As noted above, the impaired physician tends to maintain an acceptable level of clinical performance until the disorder becomes advanced. There is potential for patient harm at many levels, including failure to make a diagnosis, misdiagnosis, delay in diagnosis, inappropriate orders, poor decision making, patient harm due to physician unavailability or delay, and finally, judgment and technical errors in the operating room. The incidence of patient harm due to alcohol and substance abuse has been estimated at 1 in 10,000 patient encounters

- Loss of credentialing/licensure.

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There are major consequences to the physician themselves. Physicians may be faced with the loss of hospital credentials and loss of medical licensure. Being unable to practice results in a major loss of self identity and self worth for the surgeon over and above the significant financial loss and inability to be employed. The personal and family costs are also enormous. There is the harm to relationships with a spouse or significant other, children, and friends. Indeed, such harm to relationships may further exacerbate the alcohol or substance abuse. Finally, there are costs to society. Society has invested a great deal in the training of each and every physician. Thus, it is in society's best interest to try and restore the impaired physician, so that he or she may once again be a productive member of the medical profession.

Treatment:

Most physicians with alcohol and/or substance problems do not voluntarily refer themselves for treatment, but are instead referred by others. However, there are potential advantages for a physician who voluntarily self-refers for treatment. In many cases, they may remain anonymous to the state medical board and national practitioner data bank. (12).

- Self-assessment tools available.

A variety of tools are available to assess whether or not an individual has a problem with alcohol or substance abuse. The AUDIT-C is a 3 item questionnaire which has been shown to be a practical and valid screening tool for active alcohol abuse or dependence. (11). A more detailed screening tool, which screens not only for alcohol but substance abuse, is the Assist questionnaire, developed by the World Health Organization

- Duty to report.

The legal requirements for reporting impaired physicians and health care professionals vary from state to state. Regardless of the legal requirements, there is an ethical and moral obligation to report impaired medical professionals to help prevent harm to themselves and their patients. Initial reporting is generally to the hospital or institutional medical staff leadership so that appropriate intervention and treatment may be initiated. Such reporting is not meant to be punitive. Confidential assistance and guidance are available from regional physician health programs (<http://www.fsphp.org>). Nearly all states have a physician health program to help physicians who are impaired by alcohol or substance abuse. These programs are managed by state medical societies, state licensing boards, or sometimes a combination of both.

- High success rates with rehabilitation.

Fortunately, most physicians who abuse alcohol and drugs have characteristics which increase their chances for success with rehabilitation. Physicians have higher success rates with rehabilitation than the general population. This may be in part due to the personality type of the physician, and the rehabilitation programs that are available to them. Many physicians are highly intelligent, strong willed, and are over-achievers. As with any person who abuses alcohol and drugs, it is necessary for the patient to recognize that they have a problem. Early diagnosis is critical because physicians are often reluctant to seek help and colleagues are often reluctant to intervene (13). Physicians may voluntarily submit themselves to treatment, in which case treatment may be tailored to the particular issues involved, and may involve both inpatient and outpatient treatment. If this is done early enough, it may shorten the disruption to the patient's practice. More frequently, physicians are involuntarily referred to state physician health programs. Such residential treatment may last from 60 to 90 days, followed by a 12 step type of outpatient treatment. To ensure compliance, physicians are often monitored with randomly scheduled testing for 4 to 5 years. Completion of such treatment programs, and compliance with random mandatory testing, are usually required for restoration of hospital privileges and medical licensure (14). Participants in these programs tend to succeed, with only 22% of physicians testing positive at any time during 5 years and 71 % still

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licensed and employed at the 5 year point (15) Similar findings were noted looking at a sample of 16 state physician programs whereby approximately 75% of physicians with substance abuse disorders had favorably outcomes at 5 years (16). Overall, physicians tend to have better outcomes than the general population, with abstinence rates of 70 to 90% (3) Physicians who participate in state physician health programs are generally satisfied with the program, and 92.5 % would recommend it to others. (17). Factors increasing the risk of relapse among physicians include major opioid use combined with a coexisting psychiatric disorder, and a family history of substance abuse (18).

RESOURCES:

1. Self assessment tools:

- a) AUDIT-C (www.hepatitis.va.gov/provider/tools/audit-c.asp) a quick, 3 question tool which is highly valid in screening for problems with active alcohol abuse or dependence.
- b) NM Assist (www.drugabuse.gov/NM_assist/) a brief screening tool developed by the National Institute of Drug Abuse for screening for alcohol and substance abuse disorders.
- c) ASSIST version v3.0 (www.who.int/substance_abuse/activity/assist_v3) the Assist questionnaire is a more detailed screening tool developed by the World Health Organization for alcohol and substance abuse.

2. Referral tools:

- a) State physician health programs. Most states have a physician health program, which is either managed by the state medical society, and/or the state licensing board. Information is available from your state medical society or state board of medicine.
- b) Regional physician health program. (<http://www.fsphp.org>). Confidential help is available.

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IV. SLEEP DEPRIVATION

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To our knowledge, there has never been a surgeon who woke up in the morning thinking "How can I harm a patient today?" Yet, as we look at the effects of sleep deprivation upon ourselves and upon our surgical colleagues, we may unknowingly be causing harm to the patients we serve. Historically, sleep deprivation has not been viewed as a serious problem, although it has been looked at in the medical and surgical communities since 1988. In years past, surgeons were taught to care for patients even though we frequently had little sleep and were fatigued. Before the mandatory 80 hour residency work week, surgical residents (and surgical attendings) were intentionally trained to ignore the effects of sleep deprivation and to care for our patient's needs at the expense of obtaining renewing and invigorating sleep. Anecdotes and memories of falling asleep during rounds or while driving home are well-known. For most surgeons, it has been a point of pride to be able to work long hours and still provide good care.

Over the last several decades, the effects of sleep deprivation have been studied in several non-medical occupations and professions.¹ Sleep deprivation-related impairments in cognitive and motor performance have been equated to alcohol intoxication in multiple studies showing twenty-four hours without sleep to be equivalent to a blood-alcohol level of 0.1% (equivalent to being legally intoxicated).² Additionally, evidence of the deleterious health effects of sleep deprivation continues to increase. Included in this ever-lengthening list are the enhanced risks of diabetes, impaired cognitive function and mood, weight gain, endocrine alterations, etc. Sleep deprivation has been studied extensively among long-distance drivers and in airline pilots; this has led to mandatory federal regulations and oversight limiting duty hours in those professions. Several major national and international catastrophes have been attributed to poor cognitive function of sleep deprived workers, specifically the Three Mile Island and Chernobyl nuclear power plant catastrophes, the Exxon Valdez oil spill, and the Space Shuttle Challenger disaster.³

The effects of sleep deprivation upon health care professionals were essentially ignored until "the Libby Zion case in 1984 triggered the formation of a commission to investigate supervision and work hours of residents in New York hospitals."⁴ This particular medical catastrophe resulted in New York State guidelines and subsequent Accreditation Council for Graduate Medical Education (ACGME) requirements for medical and surgical house staff work hours and rest periods. These ACGME limits were subsequently revised and made more restrictive in 2011. (Fig. 1) These requirements were mandated after significant study looking at the effects (or lack thereof) of sleep deprivation upon medical and surgical residents in the United States.⁵⁻¹⁰

Figure 1

Duty Hours Limits	2003 ACGME Limits	2011 ACGME Limits
Maximum hours of work per week	80 hours averaged over 4 weeks	No change



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Maximum shift length	30 hours, with 24 hours for admitting new patients and then 6 hours to complete work, transfer care and education	PGY-1: 16 hours PGY2+: 28 hours; 24 hrs for new admissions; 4 hrs to complete work, transfers and education; strategic napping strongly suggested
Maximum in-hospital on call frequency	Every 3rd night, on average	Every 3rd night, on average
Minimum time off between scheduled shifts	10 hours	8 hours mandatory (10 suggested) 14 hours after 24h shift
Maximum frequency of in-hospital night shifts	Not addressed	Maximum 6 consecutive nights on night float
Moonlighting	Internal moonlighting counted in 80 hours	All moonlighting counted in 80 hours PGY-1 Not allowed to moonlight
Limit on hours for exceptions	88 hours for select programs with educational rationale	No change

Because it is counter-intuitive to think that attending surgeons are any less susceptible to the effects of sleep deprivation than surgeons in training, it is surprising to find that there are few studies evaluating the results of sleep deprivation on attending surgeons.¹¹ The effects on judgment, mood, hand-eye coordination, and the like are equally likely to affect the practicing surgeon as the resident surgeon. Most studies analyzing technical performance of surgical skills have demonstrated more errors, longer times to task completion and less efficiency in using instruments. In fact, it is arguable that as the practicing surgeon ages, the effects of sleep deprivation may be more pronounced. And while anecdotal reports exist of fatigued health care workers causing specific harm to patients, most often these have been viewed as isolated instances that do not reflect a widespread problem within our health care system.¹²

In late 2002, an article by Gaba, et al, in *The New England Journal of Medicine* contrasted and compared the effects of sleep deprivation and the potential harm to patients between resident physicians and attending clinicians. Even in this study, it was noted that "no study has proved that fatigue on the part of healthcare personnel causes errors that harm patients."¹³

Moreover, a subsequent 2009 article addressing operative complications in both the surgical and obstetrical disciplines demonstrated "Procedures performed the day after attending surgeons and obstetricians/gynecologists worked at some point during the night were not associated with significantly increased complication rates compared with control cases that were not preceded by nighttime work."¹⁴

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And, while the surgical literature contains minimal reference to actual objective complications occurring as a result of sleep deprivation among practicing surgeons, there is no mention regarding impaired surgical judgment by a fatigued surgeon. Understandably, there are no objective measuring tools to evaluate surgical judgment when the surgeon is well-rested or sleep-deprived. Clinical judgment is a subtle skill, and fatigue may contribute to errors in interpretation of radiologic studies, or perhaps a decision to delay operative intervention rather than taking the patient to the operating room. Further, in the present system, any effects of fatigue that result in bad outcomes would be self-reported.

Also noted in the article by Gaba et. al. was the lack of pressure from "market forces to address the issue of fatigue among clinicians." This excellent article suggested "The problem of fatigue-related risks in medicine will not be solved simply by limiting residents' work hours. A comprehensive strategy should include changes in organizational culture and operational safeguards, as well as provisions for ensuring that the workload of clinicians is acceptable. Although residents have been the focus of the debate, the strategy should ultimately apply to experienced clinicians as well, especially since older persons are more likely than younger persons to be adversely affected by sleep deprivation."¹³

With the ongoing changes in market forces (more employed clinicians, decreasing reimbursement, increased patient expectations, and mandates for comprehensive use of the electronic medical record, healthcare systems and hospitals currently do not have an incentive to limit surgical clinicians' work hours. Many hospitals and many surgeons have left the issue of sleep deprivation to the individual surgeon. However, the individual surgeon may be conflicted and unable to make a rational evaluation of his (her) level of sleep deprivation. "Competing interests... self-image, peer pressure, and financial pressure... can be difficult to weigh in a state of fatigue."¹⁵ Others have suggested that the patient should make the decision as to whether a surgeon "without adequate sleep" should perform an elective scheduled procedure the day after that surgeon has been on call.¹⁶ Some leaders of the American College of Surgeons rightfully question whether each and every patient scheduled for surgery can make an informed decision on the day of surgery as to whether to proceed with the proposed procedure or to reschedule, if the proposed surgeon has been up all night caring for other patients. As with the surgeon, there are multiple competing factors experienced by that surgical patient (scheduled work time off, childcare issues, financial issues, etc.).¹⁵

We feel that fatigue-related risks of harm to the surgical patient will not be eradicated by simply limiting work hours of the surgical clinicians or by leaving this issue to the individual surgeon who may not be able to make a rational decision in a fatigued state. Further, while there may be exceptions, we do not feel that the individual patient should be placed in the position of deciding whether to proceed with surgery under a particular set of circumstances that are out of his (her) control. Rather, we feel that a coordinated and systematic approach to the issue of surgical sleep deprivation will provide the best set of safeguards for the surgical patient. This systematic approach should include the Individual Surgeon, the Surgical Department, the Medical Staff, and the Hospital Administration. Further, given the regional variations of surgical practice within our country, variable solutions to the issue of sleep deprived surgeons are necessary. The guidelines that follow are intended to be general and adaptable to the various models of surgical practices in all communities. However, the goal is to address and reform potentially unsafe work practices and to safeguard the surgical patient as well as protecting the individual surgeon's wellbeing. This should be a cooperative non-punitive effort between the Individual Surgeon, the Surgical Department, the Medical Staff, and the Hospital Administration.

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GUIDELINES:

Hospital Administration: As the Hospital Administration has the authority and the responsibility to provide a safe environment for both the surgical patient and for all surgical healthcare workers within their institution(s), it should provide an objective means to evaluate each surgeon's level of sleep deprivation, depending on the situational circumstances. The Hospital and the Operating Room Nurse Manager should institute a method of identifying significant sleep deprivation among operating surgeons. While this method will vary with various clinical situations, it should ensure that a surgeon performing elective surgery has had, at a minimum, four hours of uninterrupted sleep prior to commencing elective surgery. Further, the Hospital should establish operational safeguards to prevent a fatigued surgeon from commencing surgery and mandating that surgery be delayed or rescheduled.

If an elective operative procedure must be delayed (rescheduled), then it should be rescheduled as soon as possible to minimize the inconvenience to the patient(s), their families, and the operating surgeon(s). Ideally, there should be a prospectively established mechanism (agreed to by each individual member of the Department of Surgery, the Chief of Surgery, and the Hospital Administration) to ensure that the surgical procedure is accomplished as soon as possible after the original delay. Further, there should be no penalty to the surgeon for postponement of that surgical case.

If a fatigued surgeon (either self-reported or identified by the Operating Room Staff) is asked to perform an emergent procedure that cannot be delayed, there should be a prospectively-established procedure to rapidly provide a replacement surgeon. The specifics of such an organizational mechanism for surgeon replacement will vary depending upon the specifics of each community. However, the specifics of surgeon replacement should be determined prior to an actual event and should not be established in the middle of the night (or on a weekend) when a patient is waiting for an emergent surgical procedure. Undoubtedly, such a mechanism will require input from Hospital Administration, the Surgical Department, and the Individual Surgeon.

Medical Staff: As part of the Medical Staff Bylaws and the Medical Staff Rules and Regulations, each medical staff should establish a limit on surgical work hours commensurate with the surgical needs of that community and hospital, while maintaining patient safety. This should include an acceptable workload for the practicing surgeons and a reasonable amount of night call. Limitations on length of on-call duty should be dictated by the Medical Staff, to protect the health of the surgeon and the patient. Also included in the Rules and Regulations should be operational standards regarding "hand-off" communication between on-call surgical physicians.

Surgical Department: The Surgical Department, working with the Medical Staff, should establish the policies and procedures to ensure adequate surgical staffing and reasonable patient caseloads. Further, where possible, there should be guidelines regarding taking call the night before undertaking an elective surgical schedule. (This has far-reaching implications for the Hospital and for the clinicians, and must be individualized for each hospital / community.) The Surgical Department should establish mechanisms by which availability of additional surgical clinicians can be made available to a sleep-deprived surgeon.

Individual Surgeon: "Individual surgeons should be trained in evaluating their own level of sleep deprivation as a component of providing excellent patient care."¹⁵ To this end, each attending surgeon should undergo mandatory sleep deprivation training in order to understand the insidious and harmful effects upon the neurocognitive and fine motor capabilities of every individual, particularly a surgeon. It is also important that each surgeon have an understanding of fatigue management and strategies to address fatigue on a personal level. (Figure 2) Further, since all but one of the methods of measuring sleepiness are subjective (and the objective measurement tools are



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not practical for clinical measurement of sleep deprivation effects), it is necessary that each surgeon be able to evaluate his (her) capability to safely and effectively complete a surgical procedure.

While further study is indicated to evaluate the scope of sleep deprivation among surgeons and potential harm to surgical patients, the surgical community must assume the responsibility for reforming surgical attitudes and surgical work practices "...so that exhaustion is considered as posing an unacceptable risk [to both patient and surgeon] rather than as a sign of dedication."¹³ This will be a cultural change in surgical practice with far-reaching consequences. However, without self-remediation, it is foreseeable that additional governmental regulation will be imposed upon the surgical community, just as it has been upon pilots, long-distance truck drivers and surgical residents.

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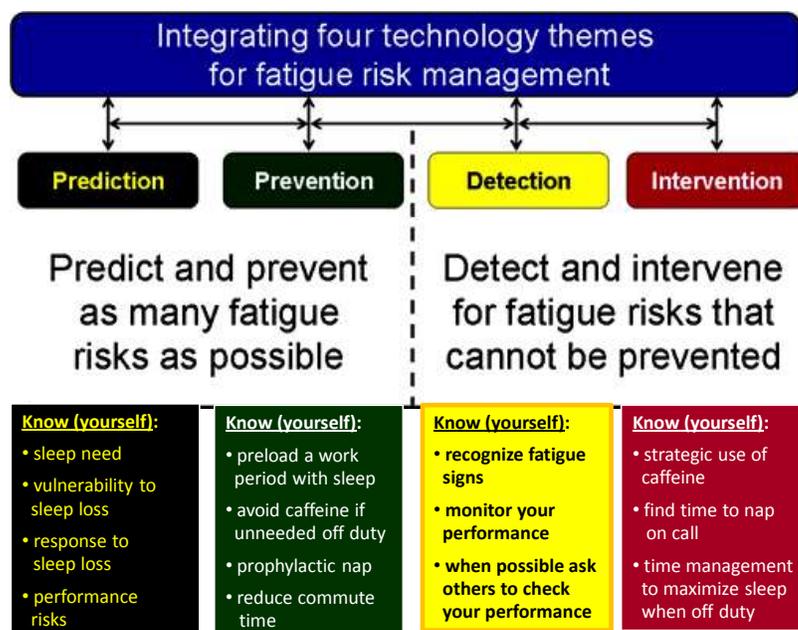
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Figure 2

Fatigue risk management is a matter of professionalism



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V. **Boundary Issues**

Jim Anderson

Introduction

Sexual misconduct can end a surgeon's career no matter how good their results are. Sexual misconduct by physicians is behavior that adversely affects the public welfare and harms patients individually and collectively. Physician sexual misconduct exploits the physician-patient relationship, is a violation of the public trust, and is often known to cause harm, both mentally and physically, to the patient.

State Medical Boards are being advised to place a high priority on investigation of sexual misconduct due to the significant threat to the public trust that sexual misconduct causes.

Definitions (per the Federation of State Medical Boards)

Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. Sexual behavior between a physician and a patient is never diagnostic or therapeutic. This behavior may be verbal or physical, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient or patient's surrogate as sexual.

There are primarily two types of professional sexual misconduct: sexual impropriety and sexual violation. Both types are the basis for disciplinary action by a state medical board if the board determines that the behavior exploited the physician-patient relationship.

Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient, that may include, but are not limited to:

1. Neglecting to employ disrobing or draping practices respecting the patient's privacy, or deliberately watching a patient dress or undress
2. Subjecting a patient to an intimate examination in the presence of medical students or other parties without the patient's informed consent or in the event such informed consent has been withdrawn
3. Examination or touching of genital mucosal areas without the use of gloves
4. Inappropriate comments about or to the patient, including but not limited to, making sexual comments about a patient's body or underclothing, making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation, making comments about potential sexual performance during an examination
5. Using the physician-patient relationship to solicit a date or romantic relationship
6. Initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician
7. Performing an intimate examination or consultation without clinical justification
8. Performing an intimate examination or consultation without explaining to the patient the need for such examination or consultation even when the examination or consultation is pertinent to the issue of sexual function or dysfunction.



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9. Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of examination or consultation.

Sexual violation may include physical sexual contact between a physician and patient, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to:

1. Sexual intercourse, genital to genital contact
2. Oral to genital contact
3. Oral to anal contact, genital to anal contact
4. Kissing in a romantic or sexual manner
5. Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, or where the patient has refused or has withdrawn consent
6. Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present
7. Offering to provide practice-related services, such as drugs, in exchange for sexual favors

Physician Education

Recognizing that physician sexual misconduct frequently has been inadequately addressed during a physician's medical training. Because of lack of education/awareness, physicians may encounter situations in which they have unknowingly violated the medical practice act through boundary transgressions and violations. A reduction in the frequency of physician sexual misconduct may be achieved through education of physicians and the health care team. Educational curricula about what is acceptable behavior in regard to boundary issues should be incorporated throughout the continuum of medical education.

Conclusion

Physician sexual misconduct can encompass a wide range of behaviors and can occur in multiple contexts. It is very damaging to patients and patient surrogates, as well as to the integrity of the medical profession. Surgeons need to educate themselves about the complexity of sexual boundaries.

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VI. Age Impairment

Kevin Garrett and Krista Kaups

Unlike other professions, there is no mandated or commonly accepted retirement age in the surgical profession. Over the last decades, surgeon age as a marker of performance has been the subject of much debate and some scholarly activity.(1 - 5). Among the areas of discussion are 1) How are surgical skills and judgment affected by the aging process? 2) Do the changes associated with aging occur uniformly in all surgeons? 3) Is self-evaluation of skills and judgment reliable? 4) Is objective assessment of surgical skills and judgment feasible or practical? 5) What options are available for the surgeon who is considering a change of practice?

According to data from the American Medical Association, many surgeons continue to practice beyond the “standard” retirement age of 65 (6, [amednews.com](#). Posted May 3, 2010.) As the baby boomer generation reaches retirement age, it is anticipated that the number of surgeons continuing to practice will increase as well. Despite this, there is a documented steady decline in the number of trained general surgeons relative to a growing and increasingly aging population (7 - 10) and a mandatory retirement age for surgeons would likely exacerbate this shortage. Surveys of surgeons indicate no consensus in favor of a mandated retirement age nor widespread agreement on when a surgeon should retire, with the decision being left to the individual. (11). A high sense of value and satisfaction experienced during active clinical practice is cited as the most common reason surgeons continue to practice (12). However inadequate retirement planning, both from a financial perspective and lack of non-surgical interests to replace clinical practice, may contribute to prolonged clinical practice (13 - 14).

The Age Discrimination in Employment Act of 1967 (ADEA) protects individuals who are 40 years of age or older from employment discrimination based on age. In direct contrast to the ADEA, numerous professionals are subject to mandatory retirement age (most notably air traffic controllers, airline pilots, FBI agents and other federal law enforcement officers). Extrapolation from these precedents leads to the viewpoint that performance is simply inversely proportional to age, causing some to advocate a “one size fits all” mandatory retirement age for surgeons regardless of performance status and without clearly supporting data (1). More nuanced observations suggest that the relationship between age and performance may not be so directly related (15). Stamina, cognition, and fine motor skills decrease with age, but not uniformly across populations; and some learned tasks and physical memory are remarkably preserved over time (4). In neuropsychological testing, decreases in cognitive processing efficiency as well as skills dealing with attention, reaction time and visual learning occur with age, as well as a decline in memory, particularly recall. Specific cognitive testing of surgeons, however, showed that the decline in reaction time was less than that of comparison groups and that the majority of practicing surgeons over 60 performed comparably to younger colleagues in all areas of cognitive testing. (14, 18) Age may be inversely related to clinical performance in primary care (16, 17), but for most procedures, surgeon age is not an important predictor of operative risk (1). Despite this, for some complex procedures (pancreatectomy, CABG, CEA), surgeons older than 60 years, with low procedure volumes relative to younger surgeons, have slightly higher mortality rates than their younger cohort (1). Aging surgeons who gradually decrease the volume of these procedures may experience a counterproductive deterioration in the skill sets necessary for their safe conduct suggesting that an “all or none” approach to larger procedures is better to maintain skills and a safe practice (1). Unfortunately, self-assessment of performance is inaccurate. In a study of 359 surgeons, subjective perception of cognitive changes did not correlate well with objective assessments (18). Other studies have supported the finding that physicians are not able to accurately self-assess performance and knowledge, with those weakest by external assessment also least effective at self-assessment (19). From a credentialing standpoint, OPPE/FPPE is designed to respond to aberrations in performance, frequently after an

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occurrence when colleagues or hospital administrators are moved to limit or terminate the surgeon's practice so are not helpful for planning purposes.

Patients, payers and hospital administrators, plaintiffs' attorneys, and physicians all have a stake in this issue which calls for an urgent response from within the surgical community to assure patients that their surgeons are safe and to avoid the imposition of external regulation (rather than thoughtful, pro-active and logical policy development). Available data support that age alone is an inadequate criterion for making retirement decisions. We recommend an individualized approach for credentialing bodies to apply focused psychomotor assessments of practicing surgeons at defined intervals, analogous to those to which we are willing to subject ourselves in order to maintain a driver's license at advanced age, as a requisite for ongoing practice (15). Various ages to begin this have been suggested ranging from 62 to 75, with 65 years appearing to be a more common threshold. Additionally, since medical issues may contribute to the decline of cognitive and technical skills, periodic medical evaluation is an essential part of the assessment. Since the individual surgeon may fail to recognize or may deny lessening skills, peer evaluation by direct observation is also important. Case review may be insufficient to evaluate subtle changes in decision-making or waning technical abilities. It is also essential that these appraisals be applied equally and take place in a confidential manner that maintains the dignity of the surgeon. For example, Stanford University Medical Center recently endorsed a policy requiring medical staff members aged 75 or older to have a "physical examination, cognitive screening and peer assessment of . . . clinical performance" every two years. "If the findings. . . point to potential concerns for patient safety, the service chief and the credentials committee will, on a confidential basis, consider the results and recommend further evaluation as necessary"(20)

Finally, we recommend that hospitals and departments of surgery explore ways to take advantage of the aggregate expertise of their senior practitioners by allowing them to continue, if appropriate, performance of adequate numbers of less complex procedures without impinging on the productivity and satisfaction of their younger colleagues (4). The cumulative wisdom and clinical experience of the senior surgeon is an invaluable asset that should not be lost. For the surgeon who wishes to continue to be engaged in surgical practice, assisting in surgery, focusing on an office-based practice or, in an academic practice, rounding on clinical services offer the opportunity for reduced work hours and flexible scheduling. Another vital role for the senior surgeon is mentoring of junior colleagues, with the mentorship ranging from informal advice to a departmentally-defined relationship. The experienced surgeon's knowledge is also valuable for the teaching of surgical topics and anatomy to both residents and medical students. Additional opportunities for the surgeon who is reducing clinical practice include administrative and quality/performance improvement activities including working with NSQIP implementation, or the ACS cancer programs.

We also recommend that surgeons seek professional guidance at the start of and throughout clinical practice to plan financially for retirement. Recent economic downturns have adversely affected retirement planning for many individuals, making careful anticipation all the more important. Even though the financial aspects of retirement are widely considered, far less attention is given to planning for meaningful activities to pursue. Development (and perhaps some trial and error participation) of activities prior to full-time retirement from practice is important. For most surgeons, it is not realistic to anticipate personal fulfillment in an abrupt transition from a busy surgical practice to a few hours of sports activities a week. In the maintenance of wellbeing throughout one's professional life, meaningful endeavors and relationships are essential.



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VII. The Disruptive Surgeon

Brian Santin MD and Krista Kaups MD

All health care professionals have witnessed coworkers, relatives, patients and other acquaintances to being ‘disruptive’ at one time or another. The dictionary defines the adjective ‘disruptive’ as causing a forcible separation or division into parts.¹⁴ It is imperative for physicians to appreciate the distinction between being disruptive and effective. For example, when a physician assumes a patient advocacy position in a conversation regarding the long-term care facility placement of an elderly gentleman, this may in fact be an appropriate and effective behavior. On the contrary, when a physician angrily demeans a nurse in a crowded hospital hallway or raises their voice shouting profanities in a committee meeting, these actions are inappropriate and disruptive. Disruptive actions listed in the AMA Model Code (2009) include: “any abusive conduct, including sexual or other forms of harassment, or other forms of verbal or nonverbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.” Specifically mentioned are:

- Physically threatening anyone [in the hospital]
- Making threatening or intimidating physical contact with another person
- Throwing things;
- Threatening violence or retribution;
- Sexual and other harassment; and
- Persistent inappropriate behavior, rising to the level of harassment.¹

With the increasing complexity of medicine, the need for well-functioning partnerships between members of the medical team becomes ever more important. At the same time, the stresses, demands and distractions for the surgeon continue to increase. (Please note that although disruptive behavior is definitely not limited to physicians, for the purpose of this document, our discussion and recommendations will be directed to physicians. As a result of the relatively high profile of physicians, disruptive behavior by physicians is perceived to have a greater impact – and greater potential for disruption).

Despite physicians’ best efforts to work with and through “the system”, most have been urgently contacted for an issue that ultimately was found to not be urgent – or found that necessary preparations were not made or equipment was not available for a procedure. Perhaps an important change in a patient’s condition was not recognized – or the physician was not notified of the change. Anger and frustration are not inappropriate; it is how the response to them is manifested that is crucial.

Although it is not evident whether the frequency of disruptive conduct has increased recently, it is clear that it is more often being recognized, studied - and penalized. In 2008, the Joint Commission issued a Sentinel Event Alert stating “Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.” A revised policy was implemented in July 2012; mandating that accredited hospitals have established mechanisms for identifying and addressing the disruptive practitioner. Large-scale studies corroborate the idea that disruptive behavior occurs frequently. In a survey of 675 nurses at 50 VA Hospitals, 86% reported witnessing disruptive physician behavior – a finding supported by the results of

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other studies.^{2,3} The majority of these incidents involved nursing staff or other health care providers. One survey of more than 800 physicians found that disruptive behavior is prevalent in more than 70% of hospitals per month.⁴ Over 10% of the physicians surveyed reported these behaviors occurring weekly. Similarly, in 2009 over 2,000 physician executives acknowledged having behavioral problems with physicians in their institution.⁵

“A single episode of disruptive behavior does not render a physician a disruptive physician”.¹⁵ Current research suggests that it is generally a small percentage of physicians who are responsible for the majority of the inappropriate behavior. Most reports describe 3 – 5 % of physicians exhibiting disruptive behavior; unfortunately it appears that surgeons are among those most identified (particularly general surgeons, neurosurgeons, cardiovascular and orthopedic surgeons).² Another important clarification is that most disruptive physicians are not “impaired” or suffering from a substance abuse pathology but are likely exhibiting long-standing behavior patterns. Estimates cite less than 10% of physician behavior issues are related to substance abuse.^{12,13}

The consequences of disruptive behavior can be significant and impact patient care. In addition, these behaviors can result in diminished morale, productivity, and create work environment disturbances with increased stress and turnover of health care employees. Collegiality is impaired when disruptive behavior is evident, leading to a less efficient and less functional team. A colleague on the receiving end of inappropriate behavior may be less likely to question orders or express concerns (e.g. discrepancies in operative consents or notification of patient-related issues) increasing the potential for medical error. As unimpeded communication becomes a casualty, patient safety is also compromised. In a survey conducted at 102 VA hospitals, with 4,530 participants, 67% of respondents felt that disruptive behavior was linked to adverse events, 71% to errors and 27% to patient mortality.² Patient and family satisfaction deteriorates when disruptive physician behavior is encountered.^{6,7} These occurrences may lead to complaints to the Medical Staff office and it has been shown that multiple complaints can serve as an indicator of a disruptive physician. When complaints to state medical boards were reviewed, 36% related to inappropriate physician behavior.⁸ Economic consequences have also been cited: slowed patient throughput due to decreased efficiency, increased employee turnover (with the resultant need to hire and retrain personnel), financial consequences to hospitals (increased errors and adverse events) and physicians (malpractice claims).⁹

The approach to disruptive behavior must be defined.

1. **Prevention:** The first step in addressing such disruptive behavior is prevention. Hospital systems should develop a clearly outlined approach to making physicians and all employees aware of what constitute disruptive behaviors as well as the consequences of these behaviors. It is essential that practitioners understand that the codes of conduct/standards apply to all health care team members. To help address the issue of disruptive behaviors, most hospital systems have implemented specific language in the Medical Staff bylaws. Of the six competencies expected of all physicians, this behavior falls under the category of Professionalism, requiring a minimum standard of behavior toward colleagues, employees and patients.¹⁰ Therefore any violation of the tenets of professionalism can serve as justification for taking action to address this behavior. The definition and expectations of professional behavior have some expected variance across health systems but do have common components.

- * Expected behaviors should be clearly delineated.
- * Consequences for divergence from these behaviors should also be delineated.
- * The type of “punishment” should be in accordance with the severity of the incident.
- * Consequences should increase in a step-wise fashion for repetitive behaviors.
- * Clear communication should occur and be documented after each and every reported incident.

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It is imperative to recognize that the individual displaying disruptive behavior(s) and the individual(s) perceiving them may view these behaviors differently. In fact, some physicians may claim that the behavior is “in the eye of the beholder”. Institution of a code of conduct applied to all health care professionals is essential. This exemplifies the importance of having a well-defined definition and foundation upon which any conversation/disciplinary action is based. It is also essential that a “due process” element be included and that “complaints should not be considered valid without a complaint verification process. Bylaws should include an appeals process with an option for a fair hearing”.¹⁵

2. Identification: If unwanted behaviors are witnessed, it is of the utmost importance to identify and report them in a timely and professional manner. Disruptive behaviors can be viewed as diminishing the strength of the healthcare team and hence very detrimental not only to other staffers, the physician involved and their personal health but ultimately patient care.⁶ Identifying disruptive behavior is the cornerstone of promoting better patient care and encouraging long lasting, meaningful relationships between all hospital staff. Most institutions recommend that reports of unfavorable physician behavior be directed at either the medical staff director/administrator or human resources. It is crucial that behavior standards are universally applied and that no perception of ‘favoritism’ occur (e.g. attitudes or actions tolerated in prominent or high-producing physicians). Formal mechanisms including detailed reporting should be in place for documenting disruptive physicians, as well as policies to protect those reporting from retaliation. Lack of reporting may be tied to fear of retaliation.

3. Acknowledgement: Addressing disruptive behavior in an informal relaxed setting with either the medical staff executive or in conjunction with a physician mentor has the greatest likelihood to result in a desirable outcome. The degree and pattern of behavior is a predictor for a positive outcome. For the physician who has an unusual and uncharacteristic outburst, a private conversation with a colleague may be most appropriate. The physician with an ongoing pattern of unacceptable behavior may best be addressed by physicians in leadership – either within the department structure or institutional physician executive structure. Unfortunately, this physician may have long-established behavior patterns – and a lack of insight into his or her behavior.¹¹ In these cases, changing the counterproductive and damaging behavior patterns is likely to require prolonged and intensive counseling programs. The lack of insight into repetitive behaviors generally requires that such physicians be mandated to enter counseling programs, as they will likely not seek this voluntarily. In a structured format, the physician’s behaviors should be discussed utilizing specific documentation and the physician provided an opportunity to evaluate their own actions and effects on others. Relevant cultural factors also need to be addressed. A plan to proceed forward should be developed, agreed to and documented with stepwise progression up to and including dismissal from the medical staff if disruptive behaviors cannot be constrained. Every hospital should have a thorough, well defined plan to subsequently help address the physician’s behavior and assist in remediation. Consequences of continued/repeated inappropriate behavior need to be explained to the physician, the conversation documented – and progress monitored. The ultimate goal of these endeavors is focused on two outcomes: improved patient care and a physician who embodies optimal behaviors and capabilities. Since most of the involved physicians are not dealing with impairment from substance abuse, referral to wellness committees or assistance programs is generally not helpful.

4. Monitoring: As part of the corrective plan, a monitoring program should be put in place. Established behavior patterns may not completely resolve immediately, and “relapses” are not uncommon but improvement must be expected. If the behaviors persist, the agreed-upon penalties need to be implemented. The monitoring period will vary but should extend at least 6 – 12 months to encourage the maintenance of appropriate behavior. Most state medical boards provide or contract with formal programs for the evaluation and rehabilitation of physicians exhibiting disruptive behavior that are available to hospitals as an option for resolution. These can be found on

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the website of the Federation of State Health Programs and the Federation of State Medical Boards (see links in Resources section). These programs provide the offending physician an opportunity to confidentially undergo rehabilitative counseling or behavior modification without jeopardizing their licensure.

Summary

*Disruptive physicians constitute 3-5% of all physicians.

*Disruptive behavior is usually not due to impairment, but the onset of disruptive behavior in a physician, who has not previously manifested it, may be an indicator of impairment (i.e. health issues, stress, etc).

*Disruptive physician behavior causes significant disruption to optimal patient care and can compromise patient safety.

*Each department or institution should have a code of conduct in place delineating behaviors that will not be tolerated; this code needs to be promulgated and accepted by all members.

*Disruptive behaviors need to be addressed in stepwise fashion and cannot be ignored.

*Inappropriate behaviors under the AMA Model Code (AMA, 2009) include, but are not limited to:

- Making belittling, personally sarcastic, or condescending statements;
- Name-calling;
- Usage of profanity;
- “Blatantly” failing to respond to patient care needs or staff requests; and
- “Deliberately” failing to return calls, pages, and messages.

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VIII. Credentialing Issues

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1. I've been reported to the state medical board's alcohol/substance abuse, what do I do?
2. I have been reported for anger/sexual harassment/disruptive physician behavior, what do I do?
3. I had my privileges restricted by my credentialing body, what are my options?
4. My license has been restricted/revoked, what are my rights?
5. I have completed a treatment program, how do I restore my license/privileges?
6. What do I disclose to the hospital, my colleagues, and my patients?

These are questions frequently encountered by our colleagues who have experienced some adverse behavior resulting in the loss of credentials and/or restriction of their medical license. As professionals, we all have significant investment in our education and careers, and for society there is a potential loss of a wealth of experience, talents and resources for the health of the people we serve. In this chapter, the goal is to define the terms used among the licensing and regulatory bodies, as well as the credentialing committees, and outline steps for individuals to use to reinstate his/herself to be a fully productive member of the medical community.

Illness is the existence of a disease, while impairment is a functional classification and implies the inability of a person affected by a disease to perform specific activities. Frequently, regulatory agencies as well as credentialing bodies use these terms synonymously; however, an illness can eventually lead to impairment if left untreated, whether it be a mental illness, physical illness or substance abuse addiction. All of us are in the profession to recognize and treat surgical illnesses early before they significantly impair an individual's ability to function. Disruptive physician behavior, as defined by the AMA is a style of interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care. In this case, physicians' behavior intimidates and demeans others, potentially resulting in a negative impact on patient care. It is not a diagnosis but could reflect underlying personality disorders, substance related disorders or psychiatric illness. Addiction is a compulsive activity or a psychological dependence of certain behavior which eventually can consume the attention of the individual to the exclusion of the other aspects of an individual's life and, thereby, creates impairment of an individual. This could include substance abuse disorder as defined by DSM-IV, or addictive illness.

The Federation of State Medical Boards is a national organization that leads the licensing community by promoting excellence in medical practice, licensure and regulation as a national resource and voice on behalf of the state medical boards in their protection of the public. The Federation of State Physician Health Programs is an association of physician health programs (PHP) which has developed the knowledge and expertise in matters of physician health. They do not diagnose and treat, but they coordinate and monitor intervention, evaluation, the treatment and the continuing care of an impaired physician, as well as those with potentially impairing illness. The PHPs have a primary commitment to uphold the mission of their state medical and osteopathic boards in order to protect the public.

The state medical board's primary goal is to protect the public through the issuance of licensure as well as administering discipline for those who violate the state medical practice act. There are approximately 70 state medical boards, including 13 osteopathic boards; several boards in the United States have dual boards. Many of us finish our training with specialty certificates and then realize that you cannot practice medicine without

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meeting a certain standard in the state in which you practice. The issuance of a license attests to meeting a minimal standard of education and training. The United States licensure exam (USMLE) is the result of a collaboration between the National Board of Medical Examiners, the Federation of State Medical Boards and the individual state licensing boards to develop uniform standards across the entire United States and Canada for the issuance of an initial license. In addition to the examination, other data is taken into consideration before the license is granted. Each state has different rules and regulations in their medical practice act, depending on the laws passed by their legislative bodies. Their overall mission is protection of the public through licensure, discipline and ensuring a minimal level of education to issue a license. Many states now require additional education beyond medical school before the issuance of a license.

A large element of a state medical board's activity is the assurance of competency, particularly in the areas of illness and impairment, by restricting licenses and mandating treatment programs. This is frequently done through the physician health programs (PHPs) that work in conjunction with the state medical board and the state medical societies; however, the PHP's should be insulated as much as possible from any political pressures and conflicting interests with the professional organizations.

Credentialing is usually done at the local hospital or health care facility that employs a physician. The Federation of State Medical Boards (FSMB) has developed a centralized credentialing bank which stores an individual's college, medical degree, initial licensure, USMLE scores and basic demographic information. This has helped facilitate new licensure applications as physicians move from state to state and into different positions, and, at the same time, protect the public from exposure to physicians who are under investigation in another jurisdiction. The local hospitals and health care facilities issue credentials depending on the individual's training and upon their needs and standards which they have established. An unrestricted license is usually mandatory; however, for those individuals who have had restriction of their license, each individual credentialing body has to establish the rules and regulations under which their practitioner is going to operate in their facility. It is imperative that each individual, depending on which jurisdiction in which they practice, be familiar with the state medical practice act and the individual rules and regulations for that legislative mandate.

Although all physicians wish to help their colleagues recover, there has to be an appropriate balance between the goals of protecting the public and the safety of their healthcare versus the recovery of the ill physician. From a practical standpoint, if one is subject to a formal complaint, either with their local credentialing body or the state board, it is important that they have self-examination of their own illness or addictive behavior. Initially, it is important to obtain the assistance of your treating physician, as well as colleagues who may assist you in recovery. However, if a formal hearing, locally or statewide, is initiated, then it is imperative that you obtain legal counsel, a lawyer familiar with administration health laws, as the rules of evidence in these hearings are quite different than in a criminal court proceeding.

It is necessary that one have complete transparency with the hospital administrative body, as well as the state regulatory agency in the hearing. Documentation of efforts to correct the illness or the impairment in a forthright manner is imperative to obtain a favorable decision by either one of those authorities. In many cases, if a patient has not been adversely affected by the individual's behavior, then the physician health program (PHP) can work in conjunction with the state regulatory agency in terms of monitoring appropriate intervention, evaluating the condition, recommending treatment and the ongoing care of a physician impaired by his illness. If anger or disruptive behavior is an issue, then there are programs to assist individuals to manage these behavior problems and ongoing monitoring and continuing reports to the appropriate authority is mandatory. If a medical license is

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encumbered, there are specific restrictive conditions that have to be fulfilled in order to have a full reinstatement of an unencumbered license. An experienced healthcare lawyer is necessary to assist one in these proceedings.

If treatment and rehabilitation is successful, the road to recovery can be difficult. There has been discrimination against recovering substance abusers but colleagues should be given the opportunity to prove themselves with careful monitoring. Most state regulatory agencies will restore a license with conditions, a public document, which can be used as guidelines for the local credentialing body. For those with substance abuse, either alcohol or drug, the usual period of observation is five years without any recidivism. This journey can be long and arduous but with determination, discipline and self-awareness of personal wellness, complete rehabilitation can be achieved. In some instances, the road to full rehabilitation is most difficult and occasionally obtainable, and one may have to choose a new, modified professional outlet. The Federation of State Physician Health Programs is an excellent resource, as well as the American Society of Addiction Medicine.

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