

VIEWPOINT

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Disrupting Disruptive Physicians

On Thursday mornings, our operating room management committee meets to handle items large and small. Most of our discussions focus on block-time allocation, purchasing decisions, and alike. However, too often we talk about behavioral issues, particularly the now well-characterized disruptive physician.

We have all seen it or been there before. A physician acts out in the operating room with shouting or biting sarcasm, intimidating colleagues and staff and impeding them from functioning at a high level. The most debilitating perpetrators of this behavior are repeat customers who engender such fear and uncertainty in all who contact them that the morale of the nursing staff and anesthesiologists is undermined, work becomes an unbearable chore, and performance suffers.

When one engages a difficult physician on his or her behavior, the physician responds in characteristic fashion. He or she defends his or her actions as patient advocacy, pointing out the shortcomings of the scrub nurse or instruments and showing limited, if any, remorse. He or she argues that such civil disobedience is the only way to enact change. In truth, disruptive physicians' actions are often admired by a sizable minority of their colleagues as the only way to articulate real frustrations of working in today's highly complex hospital. In extreme situations, these physicians become folk heroes to younger physicians who envy their fortitude in confronting the power of the bureaucracy.

A few days after a recent outburst by a particularly unpleasant and repeat offender, I was enjoying my daily interval on the stationary bicycle at my gym. My thoughts were wandering to a broad range of topics. I spent some time considering what really drives this nonproductive behavior and how otherwise valuable physicians could be channeled successfully into a more collegial state. As in the past, I was long on theory but short on conviction that it would make a difference.

After my workout as I prepared to shower, I received an urgent email. A patient I was consulting for upper extremity embolization had developed confusion and possible cerebral emboli despite full anticoagulation. I responded that I was on my way to see her and suggested a few diagnostic tests and consultations.

As I typed my message, a custodial employee of the gym reminded me that no cellular telephones were allowed in the locker room. I pointed out that I was not using my cellular telephone but rather an email function and I was not offending anyone by talking. He again pointed out that cellular telephones were not allowed under any circumstances. As I argued back, "I am a physician and this is an emergency." My voice got louder and I became confrontational. I told him to call the manager. Another member next to me said quietly that the reason for the cellular telephone ban was the photographic potential of the devices and that I could have sim-

ply moved to the reception area and used the telephone any way I wished.

I felt like the fool I was. I trudged off to the showers feeling, as in the Texas homily, lower than a snake's belly. After toweling off, I approached the employee and apologized for my behavior and for making his job more difficult. I told him he had handled the situation far better than me and I admired his restraint.

The lessons were stark and undeniable. Like my disruptive colleagues, I had justified my boorish behavior with patient care. I had assumed my need to break the rules far outweighed the reasonable and rational policy of the establishment; after all, I was important and people depended on me. Worse yet, I felt empowered to take out my frustration, enhanced by my worry about the patient, on someone unlikely to retaliate against me for fear of job loss.

I have come to realize that irrespective of disposition, when the setting is right, we are all potentially disruptive. The only questions are how frequent and how severe. Even more importantly, from a prognostic perspective, can we share the common drivers of these behaviors and develop insights that will lead to avoidance?

The most common approaches used today are only moderately effective. As in many other institutions, when physicians are deemed by their peers to have violated a carefully defined code of conduct, they are advised to apologize to any offended personnel. In many instances, these apologies are sincere and are, in fact, appreciated by all. Unfortunately, on occasion, the interaction is viewed as a forced function and the behavior is soon repeated albeit in a different nursing unit or operating room.

When such failures occur, persistently disruptive physicians are referred to our physician well-being committee. Through a highly confidential process, efforts are made to explore the potential causes for the behavior and acquaint the referred physician with the consequences of their actions on hospital function. Often, behavioral contracts are drawn up to precisely outline the individual's issues and subsequent medical staff penalties if further violations occur.

That said, as well intentioned and psychologically sound as these programs are, there remains a hard core of repeat offenders. Despite the heightened stress and ill will engendered by disruptive physicians' behavior, they simply cannot interact in other than confrontational fashion when frustrated by real or imagined shortcomings in the environment.

Based on nearly 20 years of physician management experience, it is my belief that in these few physicians, such behaviors are hard wired and fairly resistant to traditional counseling. An unfortunate end game is termination from a medical staff if the hostile working environment created by their outbursts is viewed as a liability threat by the institution. Such actions are always

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painful and bring no satisfaction to anyone involved. These high-stakes dramas, often involving critical institutional players on both sides, are played out behind closed doors. Few people are privy to the details of either the infraction or the attempts at remediation. Misunderstandings in the staff are common.

I suggest that an underused remedy is more intense peer pressure through continued education of those colleagues who might silently support these outbursts without fully realizing the consequences. This would begin by treating these incidents in the same way that we do other significant adverse events that occur in our hospitals. In confidential but interdisciplinary sessions, the genesis, nature, and consequences of the interaction could be ex-

plored openly. If indeed the inciting event was judged to be an important patient care issue, the problem could be identified and addressed yet clearly separated from the counterproductive interaction that followed. In addition to the deterrence provided by the more public airing of the incidents, the tenuous linkage between abusive behavior and patient protection could be severed. It is this linkage that provides any superficial legitimacy to the outbursts.

Through this process, peer pressure would be increased and provide a greater impetus for self-control and more productive interactions. Importantly, with such a direct and full examination of both the character and costs of poor conduct, whatever support exists for such behaviors within the medical staff would be diminished.

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VIEWPOINT

Separating the Need for Intraoperative Consultation From the Fear of Out-of-Network Billing The Myth of Drive-by Doctoring

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"Drive-by doctoring," in which questionably necessary consultants generate hefty bills to patients or insurers, has recently been highlighted by the media as a growing problem in the United States. This term was recently used to brand an incident involving a \$117 000 bill for an out-of-network intraoperative neurosurgery consultation during a routine neck surgery.¹ The widespread response from the public and media has underscored the fact that this episode may not be uncommon.

However, while drive-by doctoring may be aptly named in some cases, this term is inaccurate in many others as it conflates 2 separate issues. Intraoperative consultation is one thing; surprise out-of-network billing is another. The cases in the media seem more striking as an indicator of payer system issues and poor communication in health care than of the inappropriate use of intraoperative consultation. While these stories deserve attention, they should engender neither a sense of panic in patients over the possible consultants who may be called into the operating room during their case nor a loss of faith in surgeons. The necessity of intraoperative consultation is well founded in most cases, and there are potential solutions to keep unwarranted bills from reaching patients.

Unanticipated Consultations

Surgery inherently requires multiple sets of skilled hands. Even so-called bread-and-butter cases for general surgeons, such as laparoscopic appendectomies and cholecystectomies, often require 2 operators to safely

handle the instruments and camera. Add any unexpected findings in a routine operation, and the necessity of another surgeon increases. Anatomical variations or unexpected findings (eg, a suspected ovarian mass detected at the time of an appendectomy) may require consultation with a more experienced surgeon or a surgeon of a different specialty to complete the operation in the most responsible manner. In theory, a surgeon could simply close the patient, seek consultation, then bring the patient back to the operating room once a new plan is in place. Most surgeons, though, would likely go to great lengths to save a patient from the risks of a second anesthesia as well as the additional pain and considerable costs of a second operation.

Intraoperative consultation may also be prompted by intraoperative injuries. These technical complications unavoidably happen to all surgeons and are an accepted part of surgery. In the face of these, a surgeon must decide whether to handle an injury that may require skills beyond his or her own specialty or to call for help. In centers with specialists who are readily available, it is more prudent to call a consultant with the necessary technical skills and greater bank of experience. For instance, injury to the common bile duct during laparoscopic cholecystectomy is a serious complication that at large centers will often prompt consultation from a transplant or hepatopancreaticobiliary surgeon. For their own safety, patients should undoubtedly want these specialists in their operation if this were to occur, and surgeons in turn need to feel completely comfortable calling for help in this situation, with their decision