My Partner is a Jerk. What Can I Do?

How to handle the situation when your partner, or a member of your practice group, is disrupting the business, negatively affecting patients, or impairing office morale.

By Thomas A. Lerner

Good organizations go to great lengths to hire carefully. Most recognize that any individual that you invite into your workplace is someone with whom you will spend as much waking time–and make more important financial decisions–than anyone else, with the possible exception of a spouse.

During recruitment, care is taken to spend time with the candidate and investigate references, listening carefully for cues that anything might be amiss. As in any other courtship, however, those involved are on their best behavior, and critical judgment can be occluded by need, hope, and optimism. The "marriage" goes forward, and in two short years, your new employee is now your partner. When all goes well, the result is a collaborative, mutually supportive, and productive workplace, in which colleagues accommodate each other and physicians and staff alike enjoy coming to work and taking care of patients.

But sometimes, even after taking care in hiring, things turn sour. When problematic personality traits make themselves increasingly apparent, things get to the point where the problems that result can no longer be ignored or overlooked. Physicians and key staff who behave badly increase patient risks, undermine the mission and reputation of the practice or institution where the behavior occurs, impair morale, cause staff turnover, and may even lead to employment litigation.[1]

Managing a problematic physician is as critical as it is exhausting, and it can lead to direct and indirect financial consequences. This article addresses how some challenging behaviors manifest themselves, the potential legal and financial consequences arising from a failure to address poor conduct, and considerations of a tiered response to disruptive behavior.

While commonly thought of as a term to describe a physician with a chemical or behavioral disorder, "disruptive physician behavior" is actually a broad term encompassing the practitioner who may engage in threats, intimidation, abusive language, and demeaning behavior toward other staff and physicians regardless of any impairment.[2] The behavior may manifest itself in direct interactions or even in chart notes that snipe at the decisions or conduct of another provider. A loud and aggressive practitioner may demand more perquisites, viewing this as his due in light of the unique value he believes he brings to the practice.[3] At the same time, he may balk at taking on responsibilities that benefit the group as a whole, but which do not translate into income for himself.

Disruptive behavior can also take a more passive form. A hyper-cautious physician may become a burden on practice resources and in a group practice can impair smooth and equitable sharing of call responsibilities. The passive physician who overly narrows

1. Insurance is available for "employee acts" that lead to claims, but many businesses fail to obtain this coverage. For the relatively modest cost of the premium, the benefit can lead to a substantial savings in litigation costs and liabilities. Statutory protections for employees are generally increasing, and awareness of employee legal rights has historically been high in the Puget Sound area.

2. Federation of State Medical Boards, Policy on Physician Impairment, 2011:2013 incorporates the American Medical Association (AMA) definition of disruptive behavior as "a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behavior exhibited as a pattern of being unable, or unwilling, to function well with others to such an extent that his/her behavior, by words, attitude or action, has the potential to interfere with quality healthcare. The physician's behavior (attitudes, words, or actions) intimidate and demean others potentially resulting in a negative impact on patient care. Disruptive behavior is a descriptive label, not a diagnosis . . ." This FMSB policy statement is principally directed toward impaired physicians rather than disruptive physicians, although clearly there is overlap in those descriptions. This article is primarily focused on physician behavior, regardless of whether that is related to substance abuse or other illness.

3. Finlayson AJR, Dietrich MS, Neufeld R, Roback H, and Martin PR, "Restoring professionalism: the physician fitness-for-duty evaluation." *Gen Hosp Psychiatry 2013*; 35(6) 659-663, describes a study identifying 90 percent of the physicians referred to the Vanderbilt Comprehensive Assessment Program for fitness for duty assessments as male.

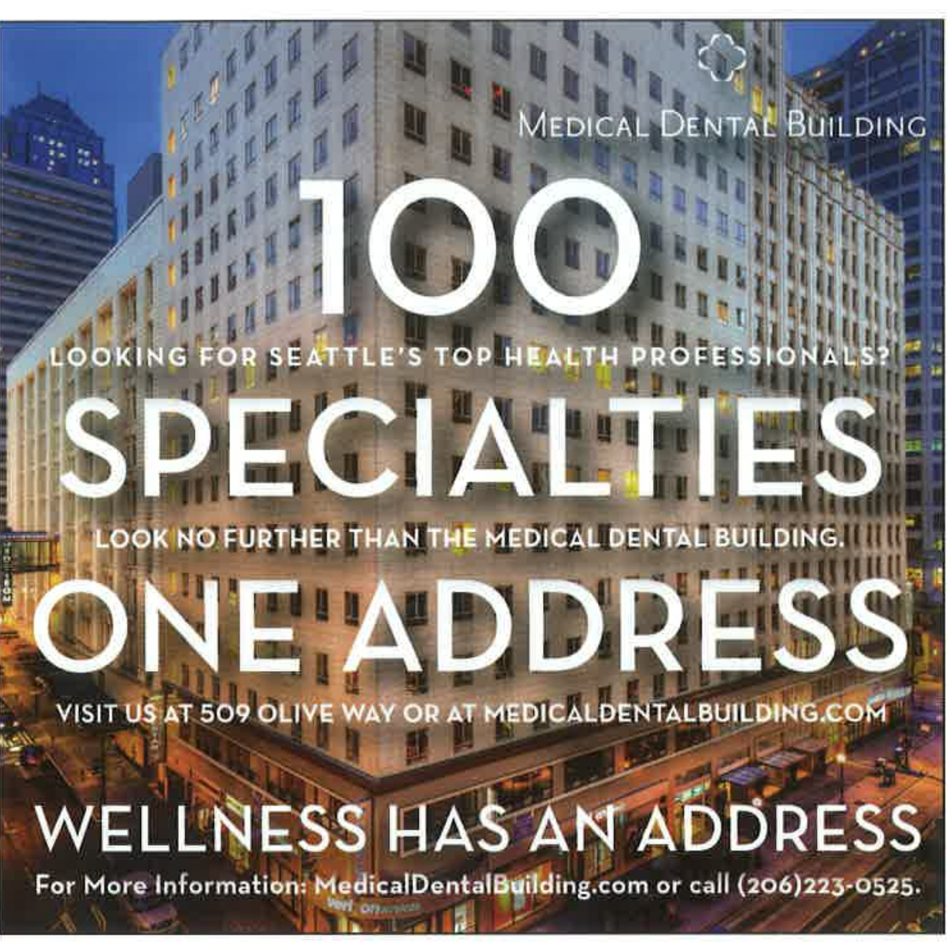
the scope of his practice, shies away from call responsibilities, or otherwise demands special scheduling considerations can also be a disruptive force in a group practice. While the loud and aggressive practitioner carries the unpredictability and explosive force of a volcano, the "passive" practitioner causes continuing wear, like sand in gears.

Each presents his own complicating traits for patient care. Staff and other physicians may avoid these practitioners, because the toll the interactions take feels too great. As a result, important communications regarding patient care may be missed. After all, it is hard to listen attentively when one feels at risk of being subjected to abusive behavior. Similarly, the intensely impatient practitioner is less likely to carefully and comprehensively communicate his instructions, thereby increasing patient risk. On the other hand, a more passive practitioner may simply become unavailable to provide timely and complete responses. A physician who fails to complete records or respond to pages in a timely manner also places patient safety at risk.

The presence of a disruptive physician of any stripe makes the workplace less hospitable. This leads to dissatisfaction and dissension among colleagues who are already struggling to navigate their practices through a continually evolving medico-legal-economic environment. Staff morale will be impaired, with the likelihood of higher turnover. Disruptive conduct could also spawn the assertion of legal claims by current or departing employees, including claims that may not be covered by insurance.[4]

As if patient safety, workplace harmony, and litigation avoidance were not sufficiently motivating factors to take early steps to manage a badly behaving physician, the legal relationship between the problematic practitioner and the group adds another layer of tension. Typically, a physician will have an employment contract with the practice group. If the physician compensation plan is production based, any interruption in the physician's ability to serve patients will have potentially significant →

4. Most businesses' general liability policies exclude most employment claims.



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ramifications for the physician's immediate or short-term income. The suggestion that a disruptive physician take a leave from the practice to engage in further training, or just to regroup and recharge, could, in that light, be met with a frosty response.

There are further obstacles to managing the situation, which can have financial consequences for both the physician and the group practice. The problem physician may also have an ownership interest in the practice, and a shareholder agreement may limit the ability of the group to impose discipline. Under the terms of the corporate documents or the employment agreement (or both), the physician may be subject to non-compete restrictions upon departure, causing the physician to stridently resist leaving voluntarily. The physician may also have an obligation to provide self-funded tail coverage upon his departure from the group, at great personal expense. There may be a contractual requirement for a lengthy notice period before termination without cause, and the departing physician may have continuing overhead obligations if he leaves without fulfilling that notice requirement. A termination of the physician's employment for cause may also trigger a reduction in the buyout paid to the physician, and almost certainly will eliminate or significantly impair any right to a severance payment. Finally, the physician's departure from the practice may trigger the practice group's obligation to purchase the physician's ownership interest, at a time when the group will also lose a physician's revenue.

All of the customary legal and financial relationships between a physician (owner or not) and a group practice warrant taking an incremental approach toward addressing a physician's bad behavior. The primary goal should be to rehabilitate the physician such that the physician is restored as a productive member of the group, with the corresponding recovery of patient safety and staff morale. In that light, an incremental approach of review, retraining, and (if all else fails) removal is generally the most prudent path.

Review

While it may seem obvious, the first step in dealing with a problematic employee is management counseling. Physicians who are subject to more abrupt or aggressive discipline complain that they did not realize they were a problem, and they do not understand why their partners did not discuss it with them. The first interactions may be framed as expressions of concern, encouraging the physician to focus on the behaviors that have drawn scrutiny. This is also an opportunity to begin to investigate whether the problem physician exhibits any other indication of impairment.

Multiple conversations between the group leader and the physician may be warranted, and each occasion should be summarized in a memo kept in the physician's personnel file. Specific behaviors should be identified, along with specific required corrective actions. These are difficult conversations, but each one should end unambiguously by identifying the problematic behavior and the minimally acceptable behavioral or performance standard. The consequences of a failure to remedy the behavior should be addressed, along with offers of encouragement or assistance to help the physician succeed. After all, there were reasons that the physician was invited to join the practice originally, and presumably those reasons still have merit. A problematic physician will be more resistant if he believes the group's focus to be adversarial. Thus, the offers of support can help reduce some of the tension inherent in the corrective process.

Retraining

Under the best of circumstances, the physician will have demonstrated communication problems and a lack of insight. This may warrant a short leave of absence while the physician attends a training and education program tailored to his apparent deficits. Suitable programs include University of California, San Diego's Physician Assessment and Clinical Education (PACE) program,[5] the University of Colorado Center for Personalized Education for Physicians (CPEP),[6] and Vanderbilt University Medical Center's Center for Professional Health.[7] Note, this is an illustrative rather than an exhaustive list. If broader impairment issues are in play, a referral to the Washington Physicians Health Program[8] may be warranted.

If the physician is resistant to participating in such a program, in the wake of repeated counseling and a failure to make remedial progress, the physician's employment agreement and (if applicable) the corporate documents should be reviewed to determine the authority of the governing body of the practice to suspend or terminate the physician's employment, and the ramifications of that action on the physician's income. A balky physician may become more motivated to cooperate if he understands that his livelihood is at risk. Most importantly, no steps should be taken without careful consideration of the consequences for patient care and the financial impact on the physician and the practice.

Removal

Sometimes, no matter how much you bail, the ship still sinks. The group may reach a point where incremental steps have been unsuccessful, and the relationship needs to be ended. Here, again, careful review of the employment and corporate documents should be undertaken. Management should be prepared to be flexible with regard to anti-competition restrictions and buyout terms. The goal, after all, is to have the physician depart without a lawsuit.

Disruptive physicians are toxic to the workplace. They make it harder to recruit and retain staff and other physicians. Their presence and conduct make patient care more difficult. It is less likely that a physician who cannot interact well with colleagues will nevertheless engage with patients with respect and patience. That has broader ramifications on the reputation of the group practice, which may well become a concern for the physicians who are the source of referrals to the group.

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5. www.paceprogram.ucsd.edu
6. www.cpepdoc.org/
7. www.mc.vanderbilt.edu/root/vumc.php?site=cph&doc=36613
8. www.wphp.org/

Was this all avoidable?

Some of the problems discussed above can be avoided by exercising greater sensitivity during the recruitment process. Sometimes these problems won't surface until well into a physician's career, and they may be triggered by other events or circumstances in the life of the physician. A divorce, burnout, boredom, or middle-age malaise can all be contributing factors that prompt changes in demeanor in an otherwise-compatible colleague. In those instances, no amount of early caution can prevent the problem.

There is a middle stage, however. Once the initial recruitment occurs, there is an almost reflexive inclination to make someone a partner if he has been appropriately productive and competent. Warning signs of future problems tend to get overlooked or dismissed because the alternative is having a hard conversation about why a competent and productive physician should not be made a partner.

Here, conflict avoidance—while more comfortable—is not the same as conflict resolution. Deferred problems rarely shrink and more often grow. The hard conversation is almost inevitable; the only question is the cost. If members of the group have misgivings about offering partnership, those concerns should be given very careful consideration before a decision is made to proceed. As hard as such a decision may seem at the time, it is worth considering the problems you may be saving yourself down the road. ■

About the Author

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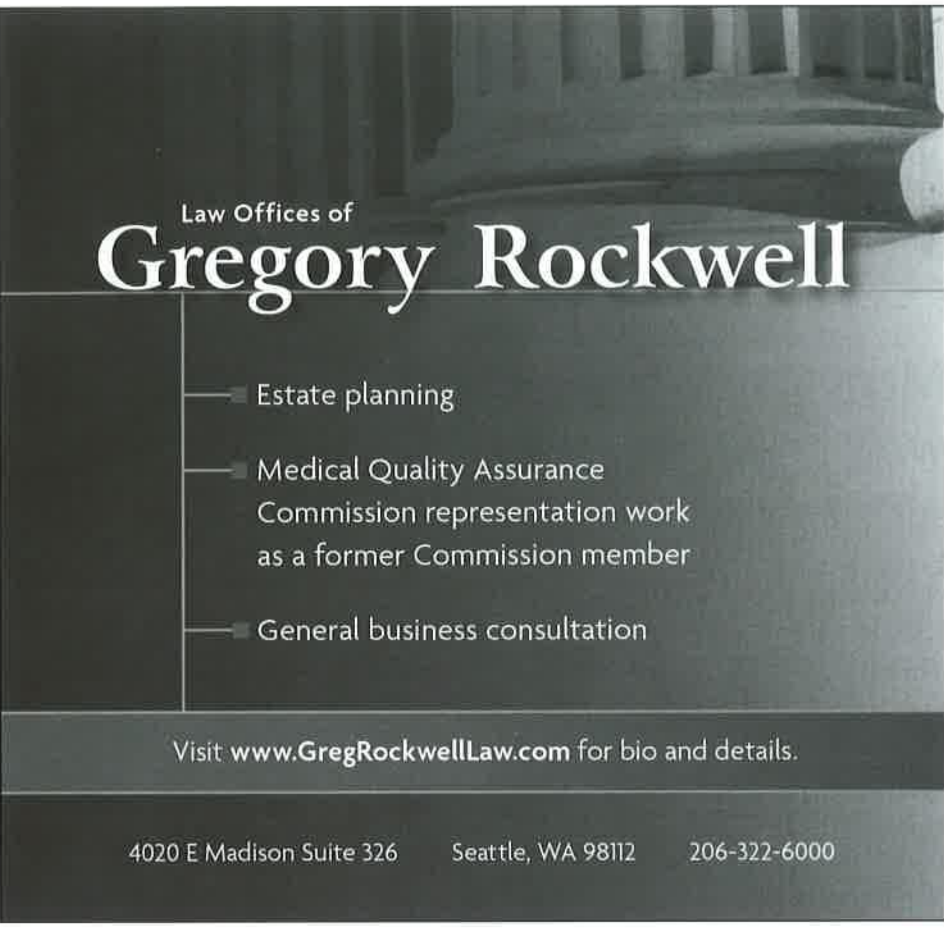

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