THE DISRUPTIVE DOCTOR

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The standard you walk past is the standard you accept – Lieutenant General David Morrison (Retd.)

We all know of clinically skilful doctors who seem to have a disproportionate number of bad days and cringeworthy behaviour. In an Australian study of formal complaints to health commissions, 3 per cent of doctors accounted for half of the complaints.

Similarly, the disruptive doctor has a disproportionate negative impact on workplace morale and teamwork, which then undermines patient care and safety.

The cause of the disruptive behaviour is often complex and multifactorial and may encompass mental health, burnout, substance use, psychosocial stressors, emotional intelligence and undeveloped interpersonal skills.

Not uncommonly, the disruptive doctor is also a distressed colleague, unaware of the impact of their behaviour on others.

Most employers, colleges and indemnity providers already have policies and deliver education on bullying and harassment and effective teamwork. There has been laudable focus on this, particularly from the AMA, RACS and RACP.

The RACS rightfully suggests as a first step asking someone you trust to speak to the doctor with disruptive behaviour who may then have the opportunity to reflect on and amend their behaviour.

However, in my experience, approaching a disruptive colleague is still frequently too hard, with reasons ranging from "It's not my job" to "I don't want to damage my career".

The few cases that follow a formal disciplinary process commonly become legalistic and unhelpful.

What I feel is generally missing is a stepped process of anonymous identification and early intervention that sits between informal collegiate coffee chats and formal disciplinary action.

There already exist evidence-based tools such as PARS® at the Vanderbilt University Medical Centre or the PRONE score built on collecting and coding anonymous patient and staff complaints to identify high-risk medicos for early intervention. The advantage of these systems is anonymous reporting and comparing data against norms including specialty context to better identify true outliers.

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A 360-degree style feedback can be a good complement but can suffer from feedback fatigue when performed regularly and it has issues with lack of anonymity.

Intervention is then tiered in order of escalation and persistence of disruptive behaviour from:

- The chat over coffee – what may be the matter
- Awareness intervention – yes there is a definite problem, how can we help
- Requesting a health and wellbeing check
- Small peer group professional development workshop for distressed doctors
- Executive coaching
- Disciplinary action.

As a high proportion of doctors who have complaints about them will suffer depression and anxiety, it is important that supports are readily accessible and that they are strongly encouraged to keep in touch with their GP.

In summary, the next step in improving medical culture is improving accountability through well-run anonymous feedback systems with a tiered approach to identify disruptive doctors who may be distressed colleagues in need of assistance. ■