

# The Tale of Dr. Wells: Competent and Irascible

## Physicians lacking strong interpersonal skills and showing signs of burnout should be referred to local wellness programs to help them be more effective and productive caretakers and colleagues.

Commentary by Michael Gendel, MD, and by Noni MacDonald, MD, and Vonda Hayes, MD

Learning Objective Identify conduct other than technical incompetence and physical impairment that can detract from physicians' effectiveness in their profession.

Learn methods for helping physician colleagues whose conduct reduces their effectiveness in patient care and resident education.

After 18 years of marriage, however, Dr. Wells divorced and returned to the US. She was dismayed to learn that she had to complete residency again in the US despite her years of successful practice and her fine reputation.

By the time Dr. Wells had finished her US surgery residency and gained staff privileges at Women's Hospital, she was almost 50. She is now 58 and is angry at the US medical education system for delaying her career; furious at US health insurance system for demanding justification of her clinical judgments, and disgusted at the young medical students and interns who have their whole lives ahead of them and complain all the time anyway.

Dr. Wells is impatient and cross with the OR nurses and has been known to throw an instrument back at a trainee who hands her the wrong one. On rounds, she asks patients how they are doing and cuts them off in the middle of their answers. She asserts, "I'm going to have a look at the incision," after she has already begun to remove the dressing and expose the incision. She has never been heard to say, "With your permission, I'd like Dr. So-and-So, and Dr. So-and-So (the residents) to have a look also." Dr. Wells has dictated false information for medical charts so that her patients could receive insurance reimbursement for an extra day or 2 in the hospital that she believed they needed. "When I have to explain medicine to some pencil pusher, that's when I'm out of here," she says. If a colleague questions a decision or suggests another possible course of action, Dr. Wells usually says, "You want to do it that way? Do it that way. I'm going ahead as planned."

Setting aside her gruffness and sometimes surly manners, Dr. Wells is a highly skilled surgeon. Her rate of complications and returns to the OR is extremely low. She has an intuition about each patient's anatomy and a deftness that, together, minimize the surgery's insult to the body she is operating on. The classes of residents are usually divided in their reactions to Dr. Wells. Some say that her insults to staff and rudeness to patients constitute a lack of professionalism that is tantamount to incompetence. Other trainees advise, "Ignore all that bedside manner stuff and watch her work. You'll learn something about surgery."

### Commentary 1

by Michael Gendel, MD

Over the years, the window for acceptable physician behavior in the workplace has narrowed considerably. Perhaps it's not as narrow as that for ordinary human beings—and I use this phrase with my tongue in cheek—but we may be

expected to behave according to usual civilized standards at some time in the future. On the surface, and the surface is quite important, Dr. Wells is behaving with arrogance, disdain for the opinions of colleagues, rudeness to nursing staff, belittling and dangerous behavior towards trainees, and a lack of empathy and respect for patients. She is compromised in her attention to the principles of medical practice that relate to interpersonal respect and care. In falsifying medical documentation she is further expressing her arrogant disregard for the rules we live by, but she is also undermining the principles of medical practice that relate to honoring the truth—the science we live by. She is endangering medicine by dishonoring herself, her colleagues, and associates. She is endangering students by throwing instruments at them and requiring them to tolerate humiliation. She is endangering patients by running over important personal boundaries, such as the consent to be examined. She is endangering her hospital by exposing it to risks of law suits by patients (malpractice) and by employees (hostile work environment) and to sanctions leveled by government agencies and insurers associated with trying to manipulate patients' benefits by falsifying information. Dr. Wells's behavior poses serious problems.

Dr. Wells is also, evidently, a talented if not brilliant surgeon who, but for these problems, would be an asset to her profession, and who has undoubtedly contributed to the health and well-being of thousands of patients. Students, too, have benefited from exposure to her, though I gather it is mainly those with enough social callus to ignore her style and behavior who are able to profit from working with her, and those more sensitive may learn little and/or be traumatized by associating with her. So we have a situation that is commonly faced by our medical community, a physician with much to offer but who is also very problematic, in this instance because of destructive attitudes and behaviors. How do we, as a community, conceptualize and approach such a problem?

Let's consider the "differential diagnosis." Is Dr. Wells's behavior a product of her personality? One can see signs of both obsessive-compulsive and narcissistic personality traits. If so, this kind of behavior should be relatively constant over time. Is her behavior a product of embitterment caused by having to retrain in a specialty in which she was previously highly regarded, going back to what she may feel are the indignities of being a trainee and losing her previous prestige? This could prove quite traumatic. If so, her difficult behavior is likely to have occurred only since she moved to the US. Could her behavior be related to a mood disorder such as depression which can reduce a physician's patience and tolerance and make her more irritable? Could she be using alcohol or other drugs excessively? Addictive disorders often present with behavioral problems even while the technical aspects of medical practice are intact. Could she be suffering from some other serious illness that she has not disclosed to any of her colleagues? If she is ill, did her depression, or addiction, or other illness begin after her move, or before? Why did she divorce and leave her adoptive country after 18 years? What happened in her marriage? Did she have behavioral problems at work in Egypt? Obviously, we have more questions than answers. To determine what is wrong beneath the surface, Dr. Wells needs expert evaluation. We cannot really prescribe an approach to the deep causes of her problems, because the "treatment" depends on the "diagnosis."

But we are not at a place where Dr. Wells's deeper issues can be addressed. Dr. Wells's difficulties must be met at the superficial level first, which means confronting her with the inappropriateness of her behavior and insisting on improvement. Because physicians are often powerful and intimidating people, this is not an easy thing to do. Often, such physicians are left alone for as long as possible which results in their engendering much hostility and fear in those around them and causes the physician to become isolated and suspicious, creating a vicious cycle and more avoidance of the problem. It is much easier to address problems early, soon after they become manifest. And addressing the problematic behavior must occur before the doctor in question can get any help.

The techniques for confronting such a physician are fit subjects for discussion, but not in this short space. The point of such a meeting is to identify the problematic behaviors, outline the expected improvements, and note the consequences of not complying. Expressing the wish to help is also essential. Referral for clinical evaluation of the problem is often appropriate, out of which treatment recommendations may flow. Referral to the state Physician Health Program will facilitate this process.

There are a couple of expressions, buzz-words of medicine, which bear discussing. Physician impairment is the inability to practice medicine with reasonable skill and safety as a result of illness or injury. Most ill physicians are not impaired at work, because, especially in chronic illness, they adapt to their condition and protect the workplace for as long as possible. The corollary of this is that if the workplace is impacted it is likely a late stage of the illness. In Dr.

Wells's case, her work is impacted. Her social skills and judgment are affected. But we don't know whether or not she is ill, so as of now, technically, I would not describe her as impaired. I would simply say that she has behavioral problems and poor judgment with intact technical skills. Physicians with behavioral problems are often termed "disruptive physicians." I don't like this term because not all behavioral problems manifest as disruption; plus, it sounds judgmental. The term reflects the anger or upset which Dr. Wells's colleagues, students, patients, and administrators likely feel toward her. It is important for those trying to intervene and help Dr. Wells to be cognizant of such anger, and to speak to and work with her from a more balanced stance.

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## Commentary 2

by Noni MacDonald, MD, and Vonda Hayes, MD

In the Tale of Dr. Anita Wells we unfortunately find a familiar contradiction for the medical profession—a physician held in high regard for her technical skills and clinical judgment but one whose colleagues express increasing concern about her interpersonal skills and manner of practice. Within the medical profession there is a growing recognition that disruptive behaviors, such as Dr. Wells demonstrates (eg, demeaning remarks, insults, and verbal put-downs), are no longer acceptable and that physicians demonstrating these behaviors need help. If help and change are not forthcoming, there is a high probability that serious problems will eventually occur for the physician, eg, reprimands, loss of hospital privileges, self-injury, patient lawsuits; for colleagues, eg, increased workplace stress and higher rates of burnout; and for the institution, eg, patient lawsuits and workplace harassment complaints. In this tale, there is the added concern that students and residents are being exposed to negative role modeling which may influence their career choices, practice patterns, and interpersonal communication styles—all of which may lead to future problems. Abusive disruptive behaviors may beget abusive disruptive behaviors and all parties suffer.

Physicians who display disruptive behaviors are particularly difficult to deal with both for colleagues and for institutions. They are often high achievers with a prodigious output of "quality" work. They can also be charming and engaging when they so choose. They are usually well-respected for the work they do and are seen as single-minded in trying to achieve their goals. New onset of disruptive behavior is especially concerning as it may reflect other problems such as chemical dependency or severe personal distress. One must not lose sight, however, of the possibility that some disruptive behavior may be precipitated or exaggerated by health care system issues that do require correction.

There are several points in the Tale of Dr. Wells which merit a closer look. The frustration and anger expressed by Dr. Wells at having had to "repeat" her training in order to work in the US is echoed by many foreign-trained graduates in similar circumstances. What are the best measures for assessing the quality and comparability of foreign training and experience? How can "the system" ensure satisfactory acclimatization to American health care standards, demands, and expectations if not through American training? Is "repetition" of training always necessary? What is the evidence? Is it possible to develop an assessment method on a more individualized basis to ensure competency?

For Dr. Wells, herself, are these behaviors new or are they of long standing? What are the causes of her anger? What

are the work-related factors? She clearly finds the health insurance system deeply frustrating, because she sees it as questioning her clinical judgment, but what are the other work-related factors that are causing her stress? Is her age affecting her ability to cope with the rigors of a full surgical workload and call? Are there more personal issues such as unresolved marital conflicts? How amicable was the divorce and are there children? How did marrying into a very different culture and working in a culture where women are valued in a different way affect how she sees herself? How is she coping as a woman in a medical field that is male-dominated with a long history of valuing "macho" behavior? Does she have serious financial retirement issues given her late start in the US system and her divorce? What are her expectations and what does she see as success? How is her health? When was the last time she had a holiday? What does she do to relieve stress and to "restore her soul"? Are there relationship issues? Does she have family or friends that support her or is she isolated?

So what are we, her colleagues and her institution, going to do when faced with this situation? Experience has shown that disruptive behavior rarely self corrects. Furthermore, long-term unresolved anger may lead to injury to others and/or to self. Patient safety is indeed an issue here.

From an institutional viewpoint, it is crucial to ensure that bylaws cover policies on appropriate behavior and conduct and that guidelines are in place with strategies to follow if the policies are contravened. Policies that define negative, unethical, and unprofessional behaviors—as well as positive behaviors to be emulated—can be more helpful than a list of disruptive behaviors alone. These policies need to be made known to all medical staff and there must be a transparent and fair process for applying them. Such policies are best accompanied by a wellness program that supports a healthy work place, works to intervene with individual medical staff before stress leads to distress, and supports medical staff in the event that distress occurs.

In the mid 1990s while at the University of Ottawa, one of the authors (NEM, a pediatric infectious disease specialist) co-chaired a task force on faculty stress with child psychiatrist Simon Davidson, which led to the development of a wellness program. Through focus groups, interactive workshops, and seminars, we learned that many academic faculty were indeed very stressed. Retirement concerns such as adequate retirement income, marital retirement issues, and worries about loss of self-esteem upon retirement were raised by many faculty of both genders in Dr. Wells's age group. Faculty in all age groups noted that concerns about privacy and confidentiality made them anxious about seeking help from inside the faculty. Yet this was coupled with a strong desire for access to the "best care" if they were to come forward for help. Many faculty expressed sadness and concern about fellow faculty members whom they noted to be in distress due to difficulties such as serious marital discord, problems with alcohol, symptoms of depression, or disruptive behaviors, but most felt impotent to help.

In response to these findings, the "Neighbourhood Watch and Connector Program" was developed. The "Neighbourhood Watch" component provides education about the markers of distress through workshops, seminars, and continuing medical education programs. Each faculty member is encouraged to look out for signs of distress among colleagues as well as within himself or herself. The "connector" component was set up to address the confidentiality and best care concerns for individuals who need help. A faculty member in distress is encouraged to call a "connector." The 5 connectors are all experienced clinical psychiatrists who determine through a brief series of questions the optimal referral for assessment, eg, psychiatry, psychology, legal, financial experts. The connector then sets up the appointment with the appropriate professional for a more thorough review assessment. All of this is done with strict adherence to confidentiality. If desired, the faculty member in distress need not even divulge his or her name to the connector. The appointment is set up using a proxy and only the expert providing the help knows the correct name. With complex cases like that of Dr. Wells, referral to more than one professional may be indicated, possibly, for example, a financial adviser, a psychologist, and a communication skills expert. For co-workers who call a connector about concerns for a colleague, the connector's role is to assist the coworker in developing options and opportunities to encourage the distressed faculty member to receive help.

Due to the high risk of negative outcomes in the Tale of Dr. Wells if her problems are not addressed, it is important that Dr. Wells be approached by a person in authority. This person should raise the concerns of colleagues using specific examples of her behavior, but must also seek out Dr. Wells's perception of how the workplace is functioning, her assessment of her performance, and what she sees as the workplace issues and problems. The person in authority who contacts Dr. Wells should also probe gently for personal issues that may be contributing to Dr. Wells's behavior.

Dr. Wells needs to hear that she is indeed valued for her technical work. With the input of Dr. Wells, it may be possible to help her recognize which elements of the problem she has some control over, eg, her verbal response to workplace situations, and also to establish what types of assistance might be most helpful to her as she works to change her behavior.

In the cases like that of Dr. Wells, one always hopes that help offered in a constructive and confidential manner will be accepted. However, often persons with disruptive behaviors do not recognize how serious a problem they have and do not readily come forward for help even when it is offered in a compassionate manner. In these circumstances, clear bylaws and the combined work of the department head, chief of the medical staff, and the vice president of medical affairs can often successfully "encourage" the staff member to get help and change these behaviors.

Her fellow coworkers may also need education on how to help Dr. Wells in her rehabilitation—perhaps a change in the call or OR schedules, a mini paid sabbatical, or other tangible change might help to show Dr. Wells that she is indeed a valued member of the staff and also give her the time to work on her interpersonal skills. Improvement in this area will benefit not only her work life but also the work life of her colleagues by decreasing their distress due to her current disruptive behaviors. In addition, the handling of Dr. Wells' disruptive behaviors in a constructive, compassionate, and respectful manner by the institution and her colleagues will provide excellent role modeling for students and residents who may need to deal with similar problems in the future.

Since 1999, we (Noni MacDonald and Vonda Hayes) have adapted and expanded the University of Ottawa program at Dalhousie University Faculty of Medicine. Taking into account our local resources and our distributed faculty, we teach in more than 100 sites throughout 3 provinces. The Wellness Program has been broadened to include not only stress and mental health issues but also physical health and workplace health including cultural and gender issues. The program (directed by VH) involves faculty, staff, students, and residents. While overnight success is not possible, there has been steady forward progress on changing the culture in the Faculty so that "care for caregivers" is becoming an accepted and valued concept. The enthusiasm of the students and the residents for the program bodes well for the future success of the profession.

## Suggested Reading

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