Forensic Psychiatric Assessments of Behaviorally Disruptive Physicians

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Forensic psychiatrists may be requested by a wide range of agencies and committees to assess physicians alleged to be behaviorally disruptive. Many of the adjudicatory procedures and questions of these agencies differ substantially from the familiar ones in civil litigation. Proximate cause and patient harm are not essential elements of the forensic questions raised by these health care agencies. In addition to assessing past professional conduct, the examiner is asked to opine about the examinee's present and future professional health and fitness for duty and what treatment or professional supervision, if any, may be needed to ensure the continuance of those professional capacities.

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While medical malpractice has long been a focus of both professional and public concern, disruptive conduct by a physician, whether or not it has resulted in patient harm, can also be the object of scrutiny and intervention by an increasingly wide array of medical administrative agencies.[1] Forensic psychiatrists may be called on to examine a physician alleged to have committed misconduct, compile a report of their findings, and make recommendations for treatment and or workplace supervision. Such a medical administrative setting differs from civil malpractice litigation. Rather than opining about damages proximately caused by an episode of negligent care, the forensic psychiatrist must form an opinion about psychiatric factors related to the examinee's past, present, and future professional capacities.

Identifying Disruptive Physician Behavior

The American Medical Association (AMA) has defined disruptive physician behavior as follows:

> Conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) [Ref. 2, p 266]

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Disruptive physician conduct can encompass a range of unprofessional expressions of emotion and uncollaborative behavior in the workplace. Disruptive physicians may display inappropriate anger and intimidate coworkers. They may deny their own responsibility for adverse events. They may perceive a complaint about them to be wholly unjustified and may be counteraccusatory, threatening retaliatory actions. Disruptive conduct may take the form of foul, sexualized, or racially inappropriate language creating a hostile or unsafe work environment. Disruptive conduct may also manifest itself by what the physician does not do, as when the physician is unresponsive to on-call pages or to other requests by health care colleagues.[3]

Such behavior may be intentional or unwitting. Irrespective of the physician's conscious intent or view of his or her own behavior, a pattern of disruptive behavior can persist despite feedback from others and attempts at corrective action. Disruptive physicians may develop a reputation, leading staff members to avoid or appease the physician and thereby compromise customary clinical practices.[3]

If the disruptive behavior is tolerated, there can be serious negative consequences for patients, health care colleagues, and the health care institution. The leadership of the hospital or physician practice may be perceived as being protective of the doctor and as not taking complaints seriously. A lack of institutional response can compromise staff morale and retention and affect patient care.[4–6] Disruptive physi-

cian behavior can influence the attitudes of staff and nurses and inhibit cooperation and team work, potentially compromising efficiency, accuracy, safety, and outcomes. A lack of response can tarnish the public perception of the hospital and erode the hospital's capacity to fulfill its institutional mission. The hospital may face staff resignations and exposure to patient and staff litigation.[7]

Reporting and Oversight Responsibilities

In 1986 with the passage of the Heath Care Quality Improvement Act,[8] the federal government created the National Practitioner Data Bank and thereby assigned most health care agencies and committees additional reporting and oversight responsibilities for physicians. In June of 2000, the AMA, based on its report, "Physicians with Disruptive Behavior," made the following recommendation:

> Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The medical staff bylaw provisions of policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness—or equivalent—committee.
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> (3) In developing policies that address physicians with disruptive behavior, attention should be paid to the following elements:
>
> (a) Clearly stating principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment.
>
> (b) Describing the behavior or types of behavior that will prompt intervention.
>
> (c) Providing a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help identify a pattern that requires intervention.
>
> (d) Establishing a process to review or verify reports of disruptive behavior.
>
> (e) Establishing a process to notify a physician whose behavior is disruptive that a report has been made, and providing the physician with an opportunity to respond to the report.
>
> (f) Including means of monitoring whether a physician's disruptive conduct improves after intervention.
>
> (g) Providing for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues," apply in particular cases.
>
> (h) Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.
>
> (i) Providing clear guidelines for the protection of confidentiality.
>
> (j) Ensuring that individuals who report physicians with disruptive behavior are duly protected [Ref. 9, p 4].

Hospitals have also been mandated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to develop specific policies for handling disruptive physicians.[10] Typically, the hospital's Medical Staff Executive Committee, which approves both physician staff appointments and the delineation of clinical privileges, also has established procedures for investigating allegations of disruptive physician conduct and responding to findings of the investigatory process. The procedures include a bifurcated pathway: one for discipline and the other for treatment and rehabilitation. Hospitals may choose to move the investigation and oversight outside of the institution to the state medical society's impaired Physicians Health Service (PHS). In the absence of serious professional misconduct and patient harm, the issue may not be further disclosed.

Many state medical societies sponsor a PHS to oversee such confidential, comprehensive assessments of physicians and also to oversee confidential treatment and rehabilitation of impaired physicians, who may have self-referred to the PHS or have been adjudicated to be impaired by a health care facility or a state medical board. Self-referral by a physician to a PHS for treatment and monitoring can be a strategic option to preserve confidentiality of a physician's history of impairment.

However, reporting certain physician misconduct to the state medical board and to the National Practitioner Data Bank may be required by state statute.[11] Findings of misconduct are often posted on the Web sites of state medical boards. The number of physicians who have been disciplined for misconduct is not insignificant. In California, four percent of physicians have been disciplined by the board. Specialties with the highest percentage included family practice, general practice, obstetrics and gynecology, and psychiatry.[12]

Most health management organization (HMO) contracts with physicians have clauses that require the individual physician to notify the HMO in the event of a finding of misconduct. Findings of misconduct by a single administrative physician oversight committee or board can thereby lead to a domino effect of removal of that physician from multiple insurance panels, including state and federal insur-

ance plans, such as Medicare and Medicaid. Information contained in the database can be used in the credentialing process. Many physicians are unaware that hospitals must access the National Practitioner Data Bank biennially to check on the status of health care practitioners. Between March 1998 and February 1999, 1,038 health care organizations were surveyed and reported that 21 percent of queries yielded previously undisclosed information resulting in changes in credentialing in 5 percent of cases.[13] Physicians charged with misconduct may justifiably feel that their professional livelihood, present and future, can be ruined.

Differences Between an Administrative Inquiry and Malpractice Litigation

Forensic psychiatrists who assess physicians whose conduct has allegedly violated other professional behavioral standards confront a series of issues that have no readily familiar analog in the civil litigation of medical malpractice. Familiarity with these differences is essential for the assessment of the defendant physician to be fair and objective and to address comprehensively the forensic questions posed.

The administrative agencies that may be concerned with physician conduct include not only state medical boards and ethics committees of professional societies but also the quality and credentialing committees of hospitals, of independent practice associations, and of third-party payers.[14]

The legal process of civil litigation has complex rules for the scope of inquiry, the definition of who can qualify to be a plaintiff, the inclusion of plaintiff and defense expert witnesses, the procedure for the examination of all witnesses, and the admissibility of evidence. Forensic psychiatric experts retained to consult and testify in malpractice actions may be accustomed to using legal definitions of imminence of risk, proximate cause of alleged damage, and the specified degree of medical certainty. Implicit in many of these concepts is the legal system's responsibilities both to the rights of the plaintiff and defendant and to the protection of the public.

However, in contrast to the legal system, medical administrative agencies are often more singularly focused on the safeguarding of patient safety within the medical institutions that they represent. Although administrative agencies must accord a defendant certain legal rights such as the cross-examination of witnesses and the right to present evidence, defendant rights are substantially curtailed when compared with those accorded a defendant in civil litigation. Though cases adjudicated by a state medical board can typically be appealed and reviewed by a civil court, state medical boards typically are granted authority and discretion in the interests of the protection of the public.

Many physicians facing allegations before a medical administrative body may not realize that they do not have the same protections they would have as defendants facing civil and criminal charges. Physician examinees are often surprised to be told that their license to practice medicine may be revoked based on the results of an administrative inquiry. The state medical board must be satisfied that every physician is fit to practice medicine. Professional fitness for duty includes not only the requisite medical or surgical skills of the physician's discipline but also the psychological fitness for the practice of medicine.

In an administrative investigation and hearing of alleged professional misconduct, neither proximate cause nor patient harm is required for the physician to be found guilty of and sanctioned for disruptive professional misconduct. Though typically physicians fear civil litigation for malpractice more than adjudication by administrative boards or committees, this attitude represents a failure to appreciate fully the professional consequences of a negative finding from an administrative hearing.

Negative judgments of a physician's conduct or professional capacity are often reported to the National Practitioner Data Bank. The physician can face long periods of supervision or other probationary professional remediation. Hospital privileges may be curtailed or withdrawn.[15] In addition, health care agencies such as hospitals, health maintenance organizations, and independent and hospital-based physician associations typically require notification by the disciplined physician of any finding by any other physician-oversight agency.

Once other health care agencies have been notified that disciplinary action has been taken against a physician, they may subject the same physician to their own investigations, scrutiny of credentials and fitness for duty, corrective supervision, probation, and even expulsion.[16] Physicians found guilty of misconduct by an administrative board can be judged by third-party payers to be ineligible for reimbursement for professional services. In this process of falling dominoes, a physician who is found guilty of misconduct

by an administrative board may no longer have access to insurance reimbursement or to the hospital or clinic locations on which his or her practice had depended.

In contrast to malpractice litigation, in which the legal fees and the cost of a finding of negligence are typically covered by malpractice insurance, a physician found guilty of misconduct by an administrative board usually has very limited coverage for legal fees incurred and no economic safety net for the financial damage that may be incurred by a formerly thriving practice.

Agency Expectations of the Examiner

A forensic psychiatrist who assesses a physician examinee against whom there have been allegations of disruptive conduct must initially clarify the following: (1) precisely what is the forensic question to be answered; (2) who is the intended recipient of the expert's report and/or testimony; and (3) is the intended recipient of the report or the examinee the financially responsible party for the services of the expert. Unlike most civil litigation in which the retaining party bears the costs of the expert, when an assessment of professionally disruptive behavior is performed, the recipient of the report may be a board or an agency (e.g., a medical society's physician health service), even though the financially responsible person is the examinee.

Most administrative agencies ask the examiner a general question about a physician examinee's fitness for duty. The question may also supply contextual information about the setting in which the examinee might practice. A forensic psychiatrist may have to become familiar with job and practice-specific problems for that examinee.[17] Forensic psychiatrists should also note in their reports that the opinions offered are limited to the relevant psychiatric factors so as not to suggest expertise about nonpsychiatric medical or surgical skills.

Agencies may also have specific criteria within their phrasing of the fitness-for-practice question that reflect the agency's specific concern or mandate. For example, state medical boards typically frame several questions to a forensic psychiatric examiner. (1) Is the physician fit to practice?[17] (2) If the answer to (1) is yes, does the physician require contemporaneous clinical and/or mental or physical health oversight to be fit to practice? (3) If the answer to (2) is yes, what are the specific types of oversight required? These forensic questions from a state medical board reflect the task-specific responsibilities of the agency. The board's responsibility is the protection of the public, and the phrasing of its questions reflects that orientation.

An organization for impaired physicians or PHS, in contrast, typically asks the examiner for a psychiatric opinion that will assist the organization in its assessment of the examinee physician's health. Opinions often need not be limited to Diagnostic and Statistical Manual IV (DSM IV) diagnoses and can include findings of both personality traits that do not rise to the syndromal requirements of a personality disorder and "V" codes. An impaired physician organization's focus is the health of the physician. Its forensic questions are appropriately broad, and the answers are intended to be used by health care providers for the oversight and treatment of the examinee.

A hospital or clinic with employees has a legal responsibility to maintain a safe working environment, free of harassment and undue risk. Such an institution would be likely to pose specific forensic questions about the examinee's potential risk to the safety of the workplace. For example, an examinee facing allegations of disproportionate anger or sexual harassment in the workplace should be examined not only about the incidents in question but also regarding the examinee's future capacity to conform his or her conduct to the behavior expected by the institution.

Hospitals and other health care institutions typically have written policies that describe the ethics-related and behavioral expectations of health care providers working in the institution. Examiners may need to respond to forensic questions in which the required institutional behavior may far exceed the requirements of the typical legal definition of the standard of care.[18] Legally, the standard of medical care is what an average practitioner would do in similar circumstances. In one author's experience (DJM), the forensic question posed was whether the examinee could conform to the relevant hospital's code of excellence, a code that clearly exceeded legal expectations of an average practitioner.

The AMA Code of Ethics,[19] the AMA's reference to disruptive physicians,[2] and the Equal Employment Opportunity Commission (EEOC) definition

of sexual harassment may be used by a health care agency to define the standard of behavior to be applied in the forensic examination and report. The institution may provide the examiner with the actual text for the wording of the standard. Some state boards of medicine have adopted relevant statements about physician conduct as a specific part of the rules that govern all physicians in that jurisdiction.[20]

When the examination has been initiated by a medical training program (e.g., a residency) or organization (e.g., a medical school) about a trainee or student, the forensic questions for the examiner frequently include a question about the examinee's fitness for learning. Military and Department of Defense agencies may have their own additional specific codes of conduct that may play a role in the formulation of specific forensic questions.

The forensic examiner's report should include the specific wording or text for the definition of misconduct that is offered by the agency requesting the assessment. In the absence of a definition specified by the institution, the examiner should clearly state the definition that the examiner applied to the examinee's behavior.

In malpractice litigation, a forensic psychiatrist offers a retrospective opinion about the defendant's past medical practices. As in malpractice litigation, a forensic psychiatrist conducting an examination for an administrative board typically opines about the past conduct of the examinee. However, unlike malpractice litigation, the question of the examinee's fitness for duty requires a prospective opinion about the examinee's present and future capacity as a physician.

Unlike malpractice litigation, in which the physician's misconduct must be the proximate cause of harm to a patient, proximate cause is not a required element of an examination of a physician for professional misconduct or for professional fitness for duty. Unlike malpractice civil litigation, in which financial compensation is offered when medical negligence has caused a patient injury, a finding of disruptive conduct by a medical administrative agency does not require that even a single patient be harmed by the examinee defendant.

Unlike malpractice litigation, in which the expert witness is retained by one side in an adversarial conflict, the forensic psychiatric examiner who is providing an agency with an expert opinion often will offer the only expert opinion.

Some administrative agencies are experienced and proficient in their adjudication of allegations of disruptive conduct and have no vested interest in the outcome of the examination. Agencies such as hospital executive committees and professional practice associations, however, may have comparatively little experience in adjudicating these complaints and may have their own legitimate concerns about liability exposure or public relations. These concerns may inappropriately affect the investigation and adjudication of the examinee. The examiner's responsibility is to strive for objectivity and remain independent of these other forces. In some cases, the examiner may have to distinguish between the physician's misconduct and organizational mismanagement of a physician under its authority (see Vignette 2).

Unlike malpractice litigation, in which the party wanting an expert opinion also pays for the expert's services, in an assessment for an administrative agency, the financially responsible party may vary.

In contrast to the forensic psychiatrist retained as an expert in malpractice litigation, the psychiatric examiner of a disruptive physician is typically asked to opine about the examinee's prospective needs for psychiatric treatment and workplace supervision. In responding to questions about the examinee's need for treatment and interprofessional oversight, the examining psychiatrist needs expertise not only in common Axis I disorders such as substance abuse,[21] affective and anxiety disorders, and psychosis, but also in the diagnosis and treatment of character pathology, whether or not the examinee's character pathology rises to the level of a DSM-IV syndromal diagnosis.

Examining forensic psychiatrists should be able to demonstrate the basis for their claimed expertise in the treatment of individuals with multiaxial pathology.[22] Psychiatrists who clinically are accustomed to delegating psychotherapy to another mental health professional or who themselves have not had substantial experience treating patients with psychotherapy should acknowledge the limits of their expertise.

The psychiatric examiner is also required to move conceptually beyond the psychiatric treatment setting and consider how to implement monitoring and supervision of an examinee in the examinee's workplace. Examiners are routinely required to make recommendations about how symptoms of a mental

illness may be manifested in the workplace and how to educate workplace supervisors regarding relevant indicators of recurrence of diagnosed psychiatric disorders.[23]

The examiner's report is often presented to individuals who have no or limited training or familiarity with mental health diagnostic and treatment concepts. Language used in a report to describe abnormal behaviors and psychiatric symptoms should be jargon free. Descriptions are best based on specific examples of the individual examinee's past behavior and dialogue in lieu of using medical language and medical concepts specific to the diagnosed disorder. Comments about an examinee's customary interpersonal style and conscious awareness of psychological and behavioral difficulties are also essential elements of the examiner's report. These commentaries serve as a guide to the agency's development of effective oversight of the physician examinee.

Recommendations for the monitoring and supervision of an examinee should include commentary about premonitory signals that could presage future psychiatric deterioration and behavioral misconduct. The examiner can also outline specific administrative and therapeutic steps that workplace monitors can take to respond in the event of the examinee's relapse. These responses, outlined in the examiner's report, can incorporate workplace requirements for safety on the one hand and the examinee's need for psychiatric privacy on the other.

In the authors' experience, it has proven helpful for a workplace monitor or supervisor of a disruptive physician to have easy access to the physician's treating clinicians for the purpose of providing the clinicians with relevant behavioral observations about the conduct of the examinee in the workplace. The treating clinicians, however, should not be expected to comment to the workplace supervisor about the physician's pathology and treatment or the management of the physician in the workplace.

Workplace monitors should have access to their own mental health consultant to aid them in acting on the recommendations of the examining forensic psychiatrist. Sometimes this role can be assumed by the initial forensic examiner if all parties are in agreement. Organizational employee assistance programs may also fulfill this role. On no account should the role be assumed by the clinician who is treating the examinee/patient.

The Examination

Some examinees are represented by counsel, but many are not. Some may believe that retaining counsel will further inflame the administrative agency. In the authors' experience, almost all of the administrative agencies do not view the choice to use legal representation to be an aggressive act. Attorneys with special expertise in this area of law can be extremely helpful to their clients in facilitating a dialogue with the adjudicating agency while advising the physician client about his or her choices. However, requests by an attorney to be present during the psychiatric examination should be respectfully declined.

At the initial meeting, examinees should be encouraged to tell the whole story, as best they know it, and to include opposing points of view, even if they believe those opposing points of view are in error. Examinees should be cautioned not to leave allegations or descriptions of events out of the narrative simply because they think the allegation is incorrect or groundless. They should be encouraged to tell the examiner the entire story, not just their side of it.

Letting the examinee narrate the events in question facilitates both the process and content of the examination. Examinees may be reassured by having an opportunity to set the record straight. The opportunity mitigates some of the anxiety and adversarial feeling that often precedes the examination and fosters a more collaborative attitude for the interview.

In addition to the effects on the working relationship between examiner and examinee, the examinee's own narrative provides essential detail about how the examinee recalls and cognitively and emotionally integrates information. The narrative provides important data about the examinee's capacity to appreciate other individuals' perspectives, whether or not the examinee agrees with those individuals. The examinee's narrative, when used in concert with other corroborative sources of information, also provides data for the assessment of the examinee's veracity. Contradictions and omissions between the examinee's version of events and the version from other sources of data should be explored fully.

Examiners typically have access to significant data about the events in question before the initial meeting with the examinee. Some examiners fully review the data before the initial interview. They find it provides the most effective way to engage the examinee rapidly with relevant questions about the core

issues in the events in question. A prior review of the data also is the most accommodating of the time and geographical constraints of many examinees who may not be available for serial interviews on different days and who also may have to be available for a separate neuropsychological assessment.

Other examiners may defer their access to other sources of data until after the initial interview with the examinee, feeling that doing so guards against negative bias toward the examinee and against premature conclusions about the events in question. With this approach, the interview will not be burdened with the examinee's expectation that the examiner has already formed an opinion against which the examinee's response will be measured, thereby fostering a more collaborative dialogue between the examiner and examinee. At a subsequent meeting, any contradictions and omissions about the events in question that have emerged can be explored.

Examinees can also be encouraged to identify an individual informant with local knowledge about the events in question whom the examiner can interview by phone or in person to obtain additional corroborative data. Such a contact can be especially helpful when the examiner has concerns about whether the examinee has been a casualty of a larger group process within the institution requesting the assessment. Examiners also should speak to referring hospital administrators or physicians, to witnesses to the event in question, and to the complainant, and attempt to clarify whether the alleged misconduct represents an isolated event or a pattern of behavior. Questions about previous peer allegations, disciplinary actions, malpractice history, and prior complaints to the state board or hospital committees may be helpful in this regard.[17] Collateral informants chosen from the examinee's family and friends can provide important data about the examinee's function in a nonprofessional setting and the contribution, if any, of substance abuse to the examinee's alleged difficulties.[17,21–23]

Assessment of the examinee's intellectual capacity is an important element of the forensic examination of any physician. In addition to the assessment of basic intellectual functions of memory, language, calculations, and drawing of geometric designs, examiners should conduct a more detailed examination of frontal lobe and so-called executive functions. These functions are especially important in clarifying whether there is an underlying organic component to an examinee's alleged behavioral departure from expected professional norms.

Examinees should be given an opportunity to demonstrate their capacity to grasp abstract intellectual themes and concepts and their capacity to use memory to manipulate and apply those concepts in serial cognitive operations. Examiners may want to consult with a neuropsychologist colleague to develop screening questions to assess the examinee's capacity for these executive functions or, alternatively, to ask a colleague to administer a neuropsychological battery. The examinee's history of management of the activities of daily living and the pattern of the examinee's reconstruction of a sequence of clinical activities and the underlying clinical decision-making may also be revealing of the examinee's underlying capacity for executive functions. Consultation with a neurologist and the use of neuroimaging may be appropriate for some examinees.

In addition to the history provided by the examinee and by corroborative sources of information, the authors routinely make use of a personality inventory (e.g., the Minnesota Multiphasic Personality Inventory [MMPI] or the Millon Clinical Multiaxial Inventory) as one part of the psychological assessment of an examinee. The data generated by this type of instrument complement rather than duplicate the data generated from direct interviews of the examinee and from other corroborative sources. Examiners can consult with their forensic psychologist colleagues regarding the applicability of different personality inventories to forensic settings and collaboratively choose accordingly.

If the interpretation of the personality inventory is consistent with the other data about the examinee, the examiner can have a higher degree of confidence in the conclusions. Substantial disagreement suggests a conflict in the data that needs further investigation to resolve the inconsistencies. One data set should not reflexively trump another. Projective testing (e.g. the Rorschach), while not routinely used by the authors, can have special utility with examinees whose responses to the personality inventory are unduly constricted. It is much harder to hide from projective testing, which requires an examinee's original responses, than from a personality inventory, that asks true/false questions.

Acute and long-term risk assessment and risk mitigation are an important part of all examinations of

allegedly disruptive physicians. An examiner's report of pertinent negative findings of risk factors may help reassure the agency. However, the predictive power of the current state of risk of an individual may fade over time. As important as current assessments of risk are the examiner's recommendations to the agency and to physician monitors of future indicators of risk for the individual examinee. An agency's understanding of the examinee's long-term vulnerabilities and the bellwether indicators of the emergence of risk will enhance the efficacy of the workplace monitors and supervisors of the examinee. The following vignettes provide some illustration of the spectrum of forensic issues encountered.

Three Vignettes

The following vignettes are fictional, were created for illustrative purposes, and do not refer to any actual individuals or events.

Vignette #1

Dr. Q. is a 60-year-old emergency room physician who was accused by a staff nurse of having responded in an angry, arrogant fashion to several emergency room patients who were intoxicated. The complaint by the staff nurse was made to the emergency room head nurse, who directed the staff nurse to fill out incident reports. The reports were then forwarded to the chief of the emergency department and to the chair of the hospital's medical executive committee.

The chief met with Dr. Q., whose wife had been seriously injured six months previously in a motor vehicle accident caused by a drunken driver. Dr. Q. also reported having symptoms of depression. Dr. Q. agreed with criticisms of his behavior and was amenable to a referral for psychiatric treatment. The subcommittee of the medical executive committee reviewed the plan and agreed that no additional action was necessary.

Vignette #2

Dr. M. is a 35-year-old ear-nose-throat (ENT) surgeon who was referred for forensic psychiatric assessment by the board of registration in medicine. The hospital had received an allegation from an operating room staff nurse that the physician had created a hostile working environment by her repeated verbal outbursts at staff for what she regarded as errors in their performance. There was no allegation of sexual harassment or of physical intimidation. No patient had been harmed.

The examination of the physician revealed that the surgeon had untreated bipolar II disorder and had maladaptive character traits that did not meet syndromal criteria of a personality disorder. The examinee expressed significant shame and guilt about her interpersonal failings and articulated an interest in treatment. Psychological testing supported the interview data and conclusions. The examiner's report recommended that the examinee receive pharmacologic treatment for bipolar disorder and psychotherapy for the character-related problems, and that the physician's treatment and workplace supervision be under the auspices of the state medical society's physician health service.

The examinee also reported that she felt the hospital administration "had it in for her" and referred the examiner to corroborating informant colleagues at the hospital. Those colleagues reported that since the purchase of the hospital by a for-profit corporation, the hospital administration had had an adversarial relationship with the nonemployee medical staff. The informants reported that, formerly, questions of physician conduct had been investigated either by the medical staff executive committee or the state medical society physician health service. They opined that the administration had intentionally referred this matter directly to the board of registration to "send a message" to the hospital medical staff.

In his report, the examiner noted the adversarial climate of the administration-medical staff relationship. The examiner recommended that the examinee's workplace monitor not only be an individual whom the examinee believed would be fair-minded but also someone who had sufficient stature and authority within the hospital hierarchy to ensure that hospital administration was not intentionally or unwittingly undermining the examinee physician.

Vignette #3

Dr. C. is a 50-year-old interventional cardiologist who was alleged to have sexually harassed a nurse. He was referred by the hospital to the PHS for assessment. When interviewed, the examinee denied the allegations and maligned the character and competence of his accuser. He described himself as altruistic, without personal conflicts, and medically prominent. He reported having acquaintances rather than close personal relationships and chose not to allow

the examiner to speak to those individuals who knew him best. Little could be determined about his life outside of the hospital.

There were substantial inconsistencies between the examinee's versions of events and the information from other sources of corroboration. The interpretation of personality inventory showed that the examinee was confident, sociable, seductive, and self-centered. The interpretation also indicated a conscious attempt to manipulate the study's results. During the course of the investigation, other nurses came forward to nursing administration with similar allegations.

The examiner concluded that the examinee had intentionally misrepresented and withheld information in an effort to escape sanction for misconduct. The medical executive committee of the hospital held a disciplinary hearing at the conclusion of which the examinee's hospital privileges were revoked. The revocation was reported to the state board of registration in medicine. The examinee's license to practice was indefinitely suspended. Several nurses filed civil suits against the examinee for sexual harassment. The hospital was not named as an object of litigation because it had acted promptly and had followed its long-established policies and procedures for complaints of sexual harassment.

Conclusions

Forensic psychiatrists may be asked to perform independent psychiatric examinations on physician examinees accused of disruptive conduct. The requests may come from any of a panoply of agencies, all of which have authority over the conduct of physicians. The requests may also originate from the attorney representing the defendant physician. Forensic psychiatrists who are accustomed to the legal guidelines of malpractice litigation should note the important differences in the procedures and forensic questions to which the examiner must respond.

Many of the core legal concepts of malpractice litigation, such as proximate cause and harm, are not essential elements of the questions posed by these health care agencies. As in malpractice litigation, an examiner is asked to form an opinion about past professional conduct of the examinee. However, unlike malpractice litigation, the examiner is asked to opine about the examinee's present and future professional fitness for duty and what treatment or oversight, if any, may be needed to ensure that fitness for duty. Unlike malpractice litigation, often there are no plaintiff and defense experts. Agencies expect the forensic psychiatrist to resist becoming an adversary to any side and to offer an objective opinion, as might a court-appointed expert in civil litigation.

The psychiatric assessment of physicians accused of disruptive behavior can offer the agencies responsible for the oversight of health care important data and perceptive recommendations on how to serve best both the public and health care professionals.

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