The Difficult Colleague Am I or is he *the problem?*

Anne Magnan

While looking at an X-ray of a multi-trauma patient in Emergency, I realized that I needed to consult with another doctor. I called the operator to know who was on call. "It's Dr. X," she told me. "Should I get him?" "Uh, no..." My last conversation with him came back to me. He had asked me in his usual gruff tone: "Hey, where did you get your medical degree? From a box of Cracker Jack?" And I thought to myself: "What a #!@?!."*

HOW COMFORTING (and easy!) to answer this question by stating that the "other person" is the problem. Unfortunately, having a difficult colleague in a team is everyone's business.

Who is "everyone"?

This "everyone" includes of course the difficult person, but also his direct superior, those being subjected to his behavior, those who witness situations, and all people aware that the person is difficult, while believing that it is none of their business.

What is meant by "difficult"?

We believe that there are two types of difficult colleagues. The first type is pretty obvious to everyone. He is impossible to ignore, as he moves like a tornado, loud, moving and throwing objects in his path! However, a difficult colleague can also be someone who cuts himself off from others, is rarely seen, who is "all work", and actually does not disturb anyone. The latter is considered difficult, because this person in our immediate entourage could be in great danger without anyone noticing. One explodes; the other implodes. In both cases, the problem involves everyone around the person.

In the medical culture, explosive behavior has traditionally not only been accepted, but also favoured at times. We all know of a difficult doctor who has impeccable skills, is at the top of his field, and becomes the example to follow by up-and-coming doctors[1].

The medical community:
1. has accepted this behavior;
2. has led us to ignore it;
3. therefore has not provided us with the tools to put an end to it.

However, society has changed, as has the medical community. Behaviors that were long unacceptable in other fields have become more disturbing than before in medicine. The willingness to eliminate this behavior has obviously come a long way.

How to recognize a difficult colleague

The literature and the experience of those involved in the Quebec Physicians' Health Program (QPHP) confirm it: when we look at the different aspects of the life of a doctor with problems (and even one with major problems), the last thing to suffer is... his work[2]! In the majority of cases, the difficult colleague remains medically competent, even when weighed down with serious problems over a long period of time. How can one approach him if he is professionally above reproach?

Most people would agree that a good doctor must have a combination of scientific, clinical and relational skills.

For a colleague having problems (whether he is difficult or not as a person), the best indication that something is not going right is **a change in behavior**, most often initially noticed by the family. The person is not necessarily sick, but may be going through trials and tribulations that have changed his way of being. Moreover, this change is generally just the tip of the iceberg. The process often has been going on for several months or even years by the time it becomes apparent at work.

The Implosive Person

A doctor facing family or conjugal problems will often prefer to deal with it by throwing himself into his work. To numb his pain, he will overperform. It is therefore important to watch out for a colleague who accepts every on-call assignment or works seven days a week.

Dr. Anne Magnan, General Practitioner, is Executive Director of the Quebec Physicians' Health Program.

TABLE 1

Behaviors to watch for

Disruptive Behaviors

- Irritability
- Cynicism
- Aggression: extreme mood changes, fits of anger, disparaging behavior
- Neglected or sloppy file-keeping
- Poor organization: incomplete files, tardiness in filling forms
- Reduced reliability, lateness
- Reduced participation in activities and on committees
- Requests for reduced workloads
- Crying (rare and most often in front of the supervisor)
- Abandoning medicine
- Work stoppages
- Suicide

Non-disruptive Behaviors

- Isolation
- Chaotic personal life
- Overwork

Isolation, overwork[2] or disturbances within a team may point to an underlying problem that could worsen.

The Explosive Person

We all know naturally gruff people whose behavior is not always appropriate, but who are not sick (and we put up with it…). However, these people can also have personal problems or become sick. Their inappropriate behavior may arise more often and become more intense, to the point where colleagues can no longer take it.

Difficult behaviors are quickly dismissed as personality disorders. When faced with these behaviors, the medical community often feels powerless. Given this reaction from peers, the person becomes stigmatized[3]. What if these conducts were initially seen as behaviors to be changed instead of a personality to be modified…?

Observed Behaviors

Whether a doctor is going through a difficult time or is sick, the behaviors observed are always the same (Table I).

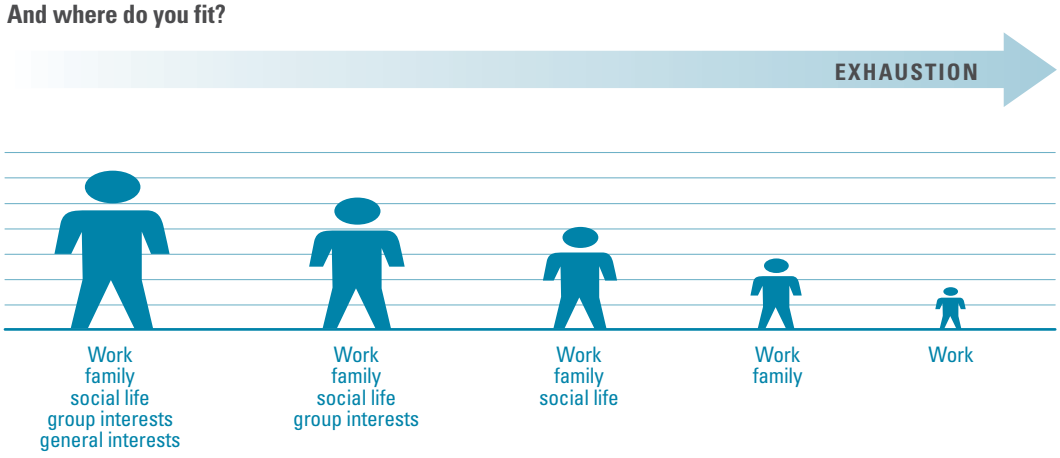
Denial

What if our difficult colleague also suffered from denial?
People generally believe that a doctor cannot be sick. Doctors themselves and their colleagues also believe this. Denial takes on unsuspected proportions in a sick doctor, because he[3]:

- has no time;[4]
- believes that his suffering is not as important as that of his patient;
- fears that he will lose his licence;
- feels failure and shame[3,5] about his own problem;
- fears disturbing colleagues;
- hides his problems in order not to have a medical file;
- has trouble accepting that he cannot work like before;
- firmly believes that he is the only one going through his situation[4].

A person with problems may not be aware of his own condition, or, if he is, may feel tremendous shame. In the medical community, mental disease stigmatizes the caregiver, who then is seen as weak and becomes a victim of rejection[3].

FIGURE 1 - Shrinking Identity (to fulfill work or be fulfilled)



* Source : Vézina M, Cousineau M, Mergler D et coll. *Pour donner un sens au travail : bilan et orientation du Québec en santé mentale au travail. Montréal : Gaëtan Morin; 1992. Authorized reproduction*

Why is it so hard to ask for help?

In addition to denial, shame[3,5], feelings of failure and the fear of being judged by the medical community, there is a set of factors that makes it very difficult to ask for help.

Individual issues

At first, doctors may have a natural propensity to deny or not take into account their own basic needs. Focused on the suffering of patients, they no longer feel their own suffering, which they consider to be less important[2,3].

For a physician, recognizing that he is sick means stopping work with all the consequences which this entails. His patients will not receive the care they need, and his colleagues must take on an overload of work. Guilt sets in.

In order to continue working at all costs, a doctor will adapt to his problems. For example, if his concentration has been affected, he will compensate by double-checking everything he does, thus investing even more time in his work. He will thus avoid anything that would allow him to recharge his batteries and safeguard his health (e.g.: music, cultural activities, sports). Many doctors have built their identity around their work. Stopping work thus threatens their very purpose in life (figure).

Cultural issues

Individual barriers are amplified by the rectitude of medical culture. Cultural stigmatization, fed by judgment, ignorance and discrimination *vis-à-vis* doctors with a mental health problem, increases suffering and isolation[3]. They foster denial of the problem, indefinitely postpone the decision to look for help, lead to self-medication[6] and increase the risk of suicide. Thus, some doctors suffer from an unrecognized, undiagnosed, self-medicated or under-treated psychiatric disease.

The sometimes insurmountable steps for obtaining disability payments[4], questionnaires from professional orders on the mental health problems of doctors (when renewing a permit), the fear of suspension, disciplinary measures or lawsuits, the discomfort of getting medication from a pharmacy, etc., are just some of the obstacles that foster this silence on part of the doctor and the community.

Protecting the public and the right of the doctor to be sick can co-exist as long as the disease does not interfere with the quality of practice[3,4]. In this context, organizations that oversee the practice of medicine have a major role to play.

The Who, When and How of Intervening

Whether it involves a doctor who makes us suffer or a doctor who is suffering (note that the former may be suffering as well), we must intervene as soon as possible after witnessing a change in behavior[7]. Intervening does not mean "solving the problem", but rather starting the process, which involves naming the problem and seeing what steps can possibly be taken.

When dealing with an explosive or implosive colleague, we must keep the following in mind:

- as an individual or team, we cannot let the situation persist, since doing nothing will sooner or later make things worse;
- the doctor concerned may not be aware of his problems;
- the doctor concerned may be aware of his problems, but does not think that they are apparent;
- by intervening, we may be faced with denial, thus the importance of sticking to the facts.

Interventions are never easy. The fears a person feels about them are legitimate, and everyone experiences the same problems:

- we have few examples to rely on;
- we feel uneasy about intervening;
- we are tempted to run away;
- we almost always think the worst-case scenario will happen.

An intervention can be a constructive discussion with another colleague about how to help the doctor troubling or worrying us in our team. If the conversation started with "We may be able to get support from the QPHP... I'll find out...", then you are already off on the right foot.

An Introduction to Inappropriate Behaviors

We have seen that a difficult colleague can be both a person who buries himself in his work and isolates himself, as well as a person who explodes.

It is easier to tell a colleague, *"It's been weeks since you stopped eating with the team, that your office door has been closed and that you've been working non-stop. I am concerned and would like to know whether you would like to talk..."* than to deal with someone who explodes at the slightest little thing.

First, let's look at what an inappropriate behavior is. According to the definition in the Labour Standards Act, psychological harassment is *"any vexatious behavior in the form of repeated and hostile or unwanted conduct, verbal comments, actions or gestures, which affects an employee's dignity or psychological or physical integrity*

and results in a harmful work environment for the employee."

The Act also specifies that *"a single serious incidence of such behavior which has a lasting harmful effect on an employee may also constitute psychological harassment."*

You should know that:

- the intention of the assumed harasser does not have to be taken into consideration;
- the words, gestures, actions and behaviors of the harasser do not have to be uttered with the intention of hurting someone;
- it is the effects on the targeted person that are taken into account.

What happens if I EXPERIENCE inappropriate behaviors?

In our society, regardless of our age, sex, work or status, we should all learn how to correctly express ourselves to other people whose behavior hurts, offends, insults, or scares us. This rule should be a must for all of us so that any unacceptable behavior falls flat as soon as it appears.

The person who has been a victim of inappropriate behavior should make it known calmly but clearly to the person exhibiting the behavior or saying hurtful things. This can be done verbally or in writing[10].

Here's an appropriate approach: "Dr. Grumpy, the tone you are using with me affects me and my performance. Since it interferes with us doing our work, I would like you to talk to me without raising your voice, and without using offensive language."

If the behavior worsens and the person affected must ask for it to stop, he could add "If your attitude towards me does not change, I will have to take the necessary steps."

In this scenario, the person:

- points out the inappropriate behavior;
- describes what he is feeling regarding the behavior deemed inappropriate;
- describes how it affects his work;
- asks for the behavior to stop;
- announces any consequences if things do not change.

Inappropriate behavior that happens once, in the heat of the moment, can be solved over a cup of coffee. For more serious or repetitive situations, a more formal interview (e.g. in the office) would be more appropriate and should encompass the five aforementioned points. If a doctor believes that he is not the best person to intervene because it involves his superior or a highly qualified doctor, admired by everyone, he can consult another person and/or the QPHP.

TABLE 2

Key elements for meeting with difficult colleagues[7]

- Communicating one's concern and desire to help
- Recognizing the good work the colleague does
- Stating the specific facts behind the problem
- Informing the colleague that some behaviors may be due to health problems without actually making a diagnosis
- Talking about the QPHP and the confidential help it offers
- Showing the possible consequences if nothing is done, and the benefits of looking for help
- Clearly stating the expected changes

What should I do if I witness inappropriate behaviors?

Witnesses are less affected emotionally in these types of situations, and therefore, have an important role to play. We should never lose sight of the fact that, if we do nothing, the problem will not solve itself.

If behaviors are ignored, they end up being tolerated and trivialized, and could end up holding everyone hostage. It is important for witnesses to intervene and make a difficult colleague aware of his disturbing behavior. The witness should intervene calmly and respectfully (he should not imitate the behavior that must be corrected), should report the facts, the way in which the behavior was perceived and the repercussions on the group's work (Table II). In certain situations, it is recommended to have two people intervene. They must be careful to listen to the version of the presumed offender, since some will admit that they did not know they were disturbing their entourage and indicate that they will pay attention in the future.

When a person denies or replies, for example, that he does not believe he is part of such a team of "wusses", those intervening may then approach a supervisor. In certain settings, a code of conduct facilitates intervention with colleagues who shrug off their behavior[7,11].

I see that what Dr. X said was disparaging. I summoned up all my courage and decided to use the "Introduction" steps. To my great surprise, Dr. X truly did not realize that he had such an effect. Since then, he has spoken to me in a more appropriate manner.

AT THE START OF THIS ARTICLE, WE ASKED the question: "Is it he or I?" In conclusion, we can see that maintaining harmony is everyone's business!

Bibliography

1. Krisek TJ. Ethics and Philosophy Lecture: Surgery… Is It an Impairing Profession? *J Am Coll Surg* 2002; 194 (3): 352–65.

2. Vézina M, Maranda MF, Gilbert MA, St-Arnaud L. *La détresse des médecins : un appel au changement.* Québec: Presses de l'Université Laval; 2006.

3. Myers MF, Gabbard GO. *The Physician as Patient: A Clinical Handbook for Mental Health Professionals.* Arlington: American Psychiatric Publishing Inc.; 2008. 242 p.

4. Center C, Davis M, Detre T et coll. Confronting Depression and Suicide in Physicians. A Consensus Statement. *JAMA* 2003; 289: 3161–6.

5. Tyssen R, Rovik JA, Vaglum P et coll. Help-Seeking for Mental Health Problems among Young Physicians; Is It the Most Ill That Seeks Help? *Soc Psychiatry Psychiatr Epidemiol* 2004; 39 (12): 989–93.

6. Kay M, Michell G, Clavarino A et coll. Doctors as Patients: A Systemic Review of Doctors' Health Access and the Barriers They Experience. *Br J Gen Pract* 2008; 5: 501–8.

7. Sotile WM, Sotile MO. *The Resilient Physician. Effective Emotional Management for Doctors and Their Medical Organizations.* Chicago: American Medical Association; 2002. 331 p.

8. Government of Quebec. *Quebec Labour Act.* R.S.Q. ch. N-1.1, subparagraphs 81.18 to 81.20, updated on May 14 2009. Quebec: Quebec Official Publisher.

9. Commission des normes du travail du Québec. *Guide de sensibilisation à l'intention des employeurs et des salariés.* Quebec: La Commission; 2008. Web Site: *www.cnt.gouv.qc.ca/fileadmin/pdf/publications/c_0246.pdf* (Date consulted: May 5, 2009).

10. Bureau d'intervention et de prévention en matière de harcèlement. *Je pense être victime.* Montreal: UQÀM. Updated on January 12, 2006. Web Site: www.harcelement.uqam.ca/victime.php?section=victime (Date consulted: May 5, 2009).

11. College of Physicians and Surgeons of Ontario and Ontario Hospital Association. *Guidebook for Managing Disruptive Physician Behaviour.* Toronto: The CPSO and OHA; April 2008. Web Site: *www.cpso.on.ca/uploadedFiles/policies/guidelines/office/Disruptive Behaviour Guidebook.pdf* (Date consulted: May 5, 2009).

Magnan A. Le collègue difficile, c'est lui ou moi le problème ? *Le Médecin du Québec* 2009 ;44 (9) : 49-54.