The Disruptive Physician and Our Role as Teachers

Toren Davis, DO

What direction do we turn when we have exhausted all avenues for change within the current system and when improvements are still needed for our patients or fellow health care professionals? Cue the disruptive physician.

The term "disruptive physician" can refer to one whose behavior and actions are detrimental to the medical system and potentially harmful to a patient's care.[1] In my experience, though, health care systems also label physicians as "disruptive" if they do not fall in line with the organizational plan, even if that plan itself is potentially harmful to patient care.

If an important faculty goal is improving medicine for our patients and peers by addressing system failures, the term disruptive physician can be used as a label to deter us from advocating for change within the current medical schema, to engender fear and steer us into compliance with the status quo. When we advocate for changes to improve patient care that will threaten well-established revenue sources and the health system's bottom line, there is usually even more pushback.

Graduate medical education teachers are role models for residents who note the choices we make when faced with system-level failures. We can either fall in line because the system called us a name, or we can creatively push for improvements because our patients and colleagues deserve better. It is with that understanding that we must shed the pejorative definition of disruptive physician given by the system and co-opt the term to embrace disruption for the betterment of our patients.

Disruption is not foreign to me. During my time as a medical director and faculty physician at a residency clinic in the southern United States, disruption was a necessary part of the job. However, this was not always so. For 4 years my team stayed within the lanes of the system in an attempt to get our patients what they needed. Like many residency clinics nationwide, our patient panel was mostly underserved and insured by Medicaid. Our clinic also mirrored the national numbers with a patient population disproportionately made up of minority patients compared to the rest of our hospital system.[2] The segregation of minoritized and underserved patients to residency clinics happens nationwide and is a symptom of a broader ailment that favors cost effectiveness over dismantling systemic racism.[3] You are probably not surprised to hear that our clinic lacked the support and resources of other primary care clinics in our own network. We lacked services critical to delivering high-quality care, such as access to basic social work and mental health services.

After 4 years of ignored ideas, requests, and proposals, our patients continued to suffer. So our team of physicians and staff transitioned to a more disruptive route of advocacy: We sent a letter to the editor of the local newspaper in October 2020. In the letter we discussed the issue of systemic racism in our medical system and how some of our most vulnerable patients were not getting the same care as others, despite repeated attempts to advocate for change.

After a hurricane of angry calls and impromptu meetings concerned that I was accusing individuals of being racist, as well as a marketing blitz to control the health system's image, there was more of an administrative response between 8:00 and 10:00 that morning than in the previous 4 years combined.

At the beginning of the COVID-19 pandemic, other hospital clinics were provided with alternate triage and waiting spaces, such as tents, to separate sick from well patients. Our clinic was denied the outdoor tents, as "too expensive." With COVID-19 already present in our community, we did not have time to debate for months with administration as to why our patients deserved the same safety measures. Instead of allowing patients with COVID-19 to be in contact with newborn, obstetric, or geriatric patients with multiple comorbidities, the clinic staff and I purchased our own tents and set up a triage area behind the clinic. This seemed like a safer approach, not just for our patients but also for our residents and staff.

Since we were rarely visited by our hospital administrators, our self-made triage area went unnoticed for nearly 3 months. When they did discover it, there was quite a commotion. They demanded that we take our tents down, but we respectfully declined as direct caregivers on the frontline during a pandemic. The tents were removed after another few weeks, but in that time our patients and coworkers had nearly 4 fewer months of COVID-19 exposure than they would if we had stayed in our system-approved lane.

DOI: http://dx.doi.org/10.4300/JGME-D-21-01121.1

I recall other examples of disruptive physician voices pushing for patient-centered improvements in care. Thousands of our underserved patients were informed that they would have to change clinicians when our hospital system let Medicaid contracts with the state lapse during the pandemic while negotiating for higher rates. The disruptive voice brought up the human consequences of the decision in attempts to hasten a solution. During the sale of our hospital, the disruptive physician contacted the state attorney general to discuss appropriate oversight of hospital sale proceeds to improve health equity, to include a review board that more closely resembled the community it served. During this time, we were also instructed to stop working with community nonprofits to address health disparities because it could interfere with hospital sale plans. We again declined to stop our patient-centered work. In each example the system had its expectations for us to follow. But in each example our patient population needed an advocate to push for change.

We now grade many residents on an advocacy milestone. Advocacy is a core piece for medicine, but it can be very hard to enact when the system you are questioning is the one in which you have worked your entire adult life and from which you desire acceptance. None of it is easy. I vividly recall taking a walk and vomiting in the bushes behind my clinic just after hitting send on our letter to the editor. I knew what awaited on the horizon. But I also knew from the previous 4 years of learning the language of business and the way our system operated that no further patient benefit would come from operating within it. Pushing a system to change will never be easy, but the disruptive physician can be a helpful tool to bring forth what former US Representative John Lewis coined, "good trouble."

There is a time and a place for the disruptive physician. It is when the system fails the people it is meant to serve. It is when systemic practices more closely resemble the original definition of disruptive by compromising the quality of care and safety of certain patient populations.[1] In such cases we must embrace the label "disruptive" if we are to use our power as physicians to create positive change for our patients. By doing so today, we model what medicine should look like for the physicians of tomorrow.

References

1. American Medical Association. Ethics. Accessed March 31, 2022. www.ama-assn.org/delivering-care/ethics
2. Kaiser Family Foundation. Distribution of the Nonelderly with Medicaid by Race/Ethnicity. Accessed March 31, 2022. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/
3. Vinekar K. Pathology of racism—a call to desegregate teaching hospitals. *N Engl J Med*. 2021;385(13):e40. doi:10.1056/NEJMpv2113508

Toren Davis, DO, is Core Faculty Physician, PeaceHealth Southwest Medical Center.

Corresponding author: Toren Davis, DO, PeaceHealth Southwest Medical Center, toren.davis55@gmail.com