



# Disruptive Physicians: From Credentialing to Disciplinary Action

## Minimizing Liability for Poor Quality of Care, Negligent Credentialing and Physician Lawsuits

**A Live 90-Minute Audio Conference with Interactive Q&A**

**Today's panel features:**

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**Thursday, August 27, 2009**

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**1 pm Eastern**

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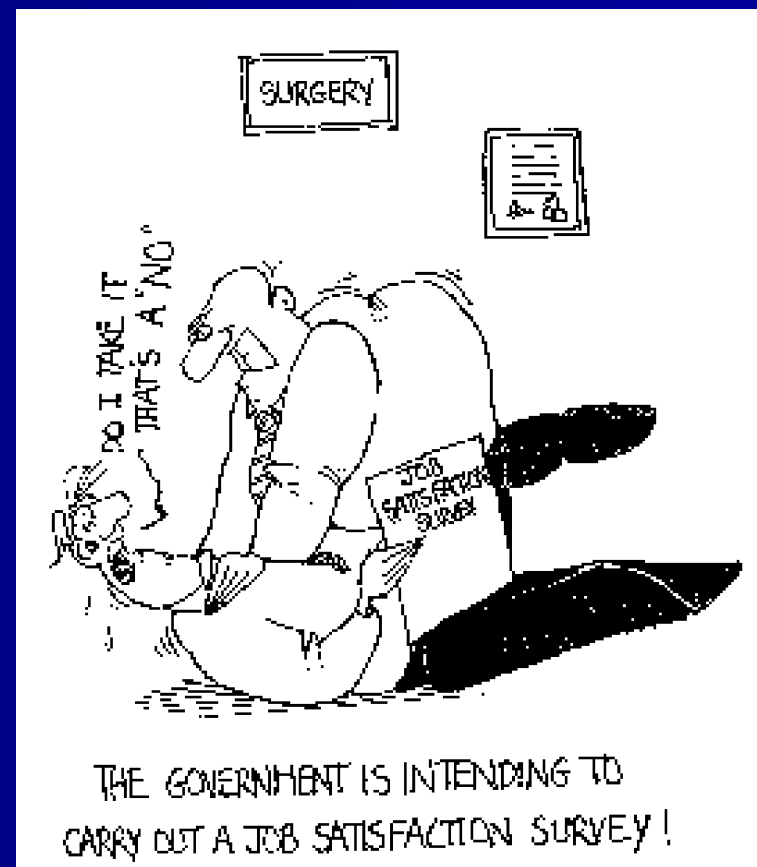
# Disruptive Physicians: From Credentialing to Disciplinary Action -- Minimizing Liability for Poor Quality of Care, Negligent Credentialing and Physician Lawsuits

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## How to Use the Credentialing Process to Appropriately Identify and Deter Disruptive Physicians

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# Defining the Disruptive Physician

- What is disruptive behavior?
- AMA Paragraph H-140.918 (“Disruptive Physician Policy”): “A style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care” or appropriate hospital operations

# Defining the Disruptive Physician

- A 2002 VHA survey of 1,200 nurses found that 92% had observed “disruptive physician behavior, such as inappropriate conflict involving verbal or even physical abuse of nurses.”  
30% said nurses had quit due to such behavior, an average of 2.4 per year per hospital (not including the severe adverse “chilling effect” on nurse recruiting)
- Failure to act exposes the hospital to risk of negligent credentialing and other lawsuits from injured patients, “hostile work environment/sexual harassment” litigation by nurses and other hospital employees, and even tort actions from injured visitors.

# Sources of Stress on Physicians

- Overly regulated and second-guessed
- Constantly threatened with meritless litigation
- Underpaid
- Buried under third-party payor and regulatory “red tape”
- Under-appreciated
- Frustrated by inadequate facilities, insufficient trained staff
- Overly criticized
- Not in control of their work environment

# Defining the Disruptive Physician

## ■ Examples of Disruptive Behavior:

- Physician abusively berates colleagues, residents, nurses and hospital administrative and staff (particularly in front of others) for not performing up to his or her standards. Objective, cold, unimpeachable criticism is more effective; e.g., “I used to think this nurse was competent, but then she did this. I’m not so sure now.”
- Physician engages in other types of repeated obnoxious, harassing, profane, bizarre or otherwise inappropriate behavior that adversely affects patient care
- Physician repeatedly fails to complete paperwork on a timely basis.

# What is Disruptive Behavior?

- Inappropriate anger can lead to:
  - Abusive language (including severe and persistent sarcasm)
  - Harassing or intimidating behavior
  - Publicly blaming others for adverse outcomes
  - Threats of retribution, including ruining professional careers, litigation or even physical violence (In at least two actual cases, a car-bombing or threat to do so!)

# What is Disruptive Behavior?

- Verbal or physical attacks that go well beyond the bounds of fair professional conduct, which may include:
    - Sexual comments or innuendoes
    - Sexual harassment
    - Seductive, aggressive or assaulting behavior
    - Racial or ethnic slurs
    - Constant foul language or lack of regard for personal comfort and dignity of others
- (Only “Gregory House, M.D.” can routinely get away with such behavior. . .)

# What is Disruptive Behavior?

- Inappropriate responses to patient or staff needs, including:
  - Late or otherwise unsuitable replies to pages or calls
  - Unprofessional demeanor or conduct
  - Uncooperative, defiant approach to problems
  - Rigid, inflexible or explosive responses to requests for assistance or cooperation
  - Inappropriate or disrespectful comments (or illustrations, in one case) made in patient medical records or other documents

## Distinguished From “Whistle Blower” or Other Strong Patient Care Advocate

- However, a “disruptive physician” must be distinguished from a physician who poses no serious adverse threat to patient care but (i) is merely annoyingly intense or colorful or arrogant by nature, or (ii) severely criticizes hospital administration or operations; or (iii) advocates strongly (perhaps wrongly but not irrationally) for quality patient care

## Distinguished From “Whistle Blower” or Other Strong Patient Care Advocate

- For example, California law expressly makes it illegal, to “penalize . . . a physician . . . principally for advocating for medically appropriate health care . . . nor shall any person prohibit, restrict, or in any way discourage a physician . . . from communicating to a patient information in furtherance of medically appropriate health care.”

[California Business & Professions Code §2056]

## Distinguished From “Whistle Blower” or Other Strong Patient Care Advocate

- Under the California statute, “to advocate for a medically appropriate health care” is defined to mean, inter alia, “to protest a decision, policy or practice that the physician . . . reasonably believes impairs the physician’s ability to provide medically appropriate health care to his or her patients.”

[California Business & Professions Code §2056]

## Distinguished From “Whistle Blower” or Other Strong Patient Care Advocate

- Sometimes called “Sham Peer Review”
- New California Law: AB 632/Section 1278.5 of the Health and Safety Code (became effective 1/1/08). Prohibits retaliation against medical staff “whistle blower.”
  - Provides for unlimited damages
  - Controversial because could disrupt active peer review proceedings (apparent exception to “exhaustion of administrative remedies requirement)

## Distinguished From “Whistle Blower” or Other Strong Patient Care Advocate

- A willful violation of the new California “whistleblower” statute is also a criminal misdemeanor punishable by fine up to \$20,000
  - May also eliminate Health Care Quality Improvement Act immunity for peer reviewers, if facts show corrective action was merely a pretext to remove a physician for complaining about hospital or medical staff problems
  - Pretext presumed if there is evidence of “whistleblowing” by that M.D. within 120 days prior to date corrective action commenced

## Distinguished From “Whistle Blower” or Other Strong Patient Care Advocate

- Wilkey v. McCullough-Hyde Mem. Hosp., 2007 U.S. Dist. Lexis 79959 (S.D. Ohio 10/18/07)
  - Dr. Wilkey’s medical staff privileges were revoked for “disruptive behavior” after he complained about equipment and scheduling problems affecting patient care
  - First external reviewer was a competitor; second external reviewer’s report was favorable to Dr. Wilkey but not provided to Dr. Wilkey or some of Credentials Committee and MEC members. MEC then revoked his privileges
  - Court ruled in favor of Dr. Wilkey

## Nevada Supreme Court Decision in *Clark v. Columbia/HCA Information Serv., Inc.* 25 P.3d 215 (Nev. 2001)

- Dr. Clark was considered “disruptive” because, among other things, he reported concerns about the quality of patient care to outside agencies and made statements critical of the hospital
- The peer review board concluded that his reports to outside agencies were disruptive and would “eventually have an adverse impact on the quality of health care.” The board terminated his medical staff privileges

*Clark v. Columbia/HCA Information Serv., Inc.*  
(continued)

- The Supreme Court of Nevada held in favor of Dr. Clark that the peer review committee and the hospital were not immune from suit under the federal Health Care Quality Improvement Act, because the revocation of Clark's staff privileges was not made with the reasonable belief that it was in furtherance of quality health care (Compare California Business & Professions Code §2056, cited above)
- The Court also ruled that, because Dr. Clark had apparently been a "whistle blower," it was against public policy to enforce any contractual release from liability that he had signed

California Appellate Court Decision in  
*Johnson v. Riverside Healthcare System LP*  
App. No. E 0384/10 (10/18/07)

- However, a 2007 California court decision gives comfort to hospitals and medical staffs: The Judicial Review Committee's action to deny reappointment of physician who was clinically competent but "complicated scheduling, delayed patient surgeries and . . . put patient lives at risk" was upheld by the court, which found that the plaintiff "physician exhibited abrasive and disrespectful conduct toward nurses" other staff to the extent they were unwilling to work for him."

## Negligent Credentialing

- In Larson v. Wasemiller, 738 N.W.2d 300 (MN Sup. Ct. 2007), the Minnesota Supreme Court held that patients can sue hospitals for allegedly granting privileges to physicians with questionable credentials. The hospital was held liable for such “negligent credentialing,” which in theory may also apply to physicians who are credentialed despite known histories of disruptive behavior adversely affecting patient care.

# Negligent Credentialing

- In Larson v. Wasemiller, the medical staff missed, ignored or downplayed the applicant's serious past problems.
- Plaintiff found through non-privileged public court records that, before Dr. Wasemiller performed gastric bypass surgery at St. Francis with major complications that also resulted in a medical malpractice action, he (i) had failed his surgical board exams three times, (ii) had failed to complete successful additional year of surgical residency, (iii) was unable to obtain medical malpractice insurance in the private market, (iv) had several lawsuits after patients died or had serious complications, and (v) had several pending disciplinary actions.

# Negligent Credentialing

- Could apply to admitted applicant who has history of serious disruptive behavior that might pose threat to patient care
- Decision in Larson v. Wasemiller created double-bind for the hospital: confidentiality of peer review records (criminal misdemeanor to breach confidentiality in Minnesota) prevented the hospital from fully defending itself.
  - Concurring judge's opinion called for the Minnesota Legislature to amend the peer review law.

# Impaired Physicians

- Under the Medical Staff Bylaws, “impaired physicians” to be handled separately from other types of disruptive physicians.
  - The Joint Commission requires a non-disciplinary process that complies with The Americans with Disabilities Act (“ADA”) for substance abuse as well as depression and other mental health disorders (under the American Psychiatric Association’s Diagnostic and Statistical Manual – IV).
  - The ADA and the EEOC mandate “reasonable accommodations” (if possible) for a “qualified individual” with a “disability,” which applies to physicians who can perform all of the essential functions of their job.
  - **Note**, however, that the ADA does **not** apply to physicians (i) with sexual disorders, (ii) with substance abuse disorders due to current illegal drug use, or (iii) who threaten the health and safety of others.

# The Application Screening Process

It is legally safer and easier to keep out questionable applicants than to remove “bad actors” from the Medical Staff.

- The Medical Staff Application should clearly state that, as a condition of being granted Medical Staff member and privileges at Hospital, all Applicants understand that they are required, among other requirements, to agree to treat other physicians as well as employees, patients, and visitors at Hospital in a professional and courteous manner and to refrain from disruptive conduct that adversely affects Hospital patient care and operations (attach to the application a copy of the Medical Staff Code of Conduct, if any).
- The signed Application then constitutes evidence that the Applicant has been fully warned of the Medical Staff’s Policy and his or her future obligations.

## Recommendation: Joint Committee of Medical Staff and Nursing Staff Leadership

- A Joint Committee of Medical Staff and Nursing Leadership should be tasked with creating (with the approval of the Medical Staff and the Hospital Board) an environment that is
  - Professional
  - Collegial
  - Free from harassment/unlawful discrimination
  - Compliant with federal/state laws
  - Consistent with a high standard of professionalism
  - Supportive of continuous peer review and quality improvement
- Can address disruptive nurses and other hospital personnel too
- Dialogue alone may reduce conflict

Recommendation: Written Code of Conduct Signed By All Medical Staff Members As Condition of Medical Staff Membership

- **Effective January 1, 2009, Joint Commission Leadership Standards**

- “EP 4: the hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.” (Emphasis added.)
- “EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.”

## Recommendation: Written Code of Conduct Signed By All Medical Staff Members As Condition of Medical Staff Membership

- Medical Staff (or its Joint Committee) should adopt a written “Code of Conduct”
- Purpose:
  - Establish detailed appropriate behavioral guidelines from the outset. **All applicants for appointment and reappointment should receive the Code of Conduct and agree to abide by it as condition of medical staff membership**
  - Deterrent effect: physicians who conclude they cannot exercise sufficient self-control to abide by the Code of Conduct are deterred from joining the Medical Staff
  - Easier to enforce corrective action against physicians who sign the Code of Conduct and subsequently violate it



# **Disruptive Physicians – Joint Commission, Employment and Medical Staff Bylaws Issues**

**August 27, 2009**

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# Employment issues with disruptive practitioners

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Disruptive practitioners may be:

Attending physicians/members of the medical staff, or

Employed and members of the medical staff

Institution may have to analyze both:

1. Employment issues
2. Medical Staff issues

# Employment issues

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If the practitioner is employed, consider:

- Does s/he have an employment contract, and what does the contract say re (i) termination, (ii) breach, (iii) code of conduct, (iv) medical staff privileges in event that employment terminates
- Does the institution have any employment policies that address the situation?
- Are there any concerns from an employment standpoint (e.g., whistleblower issues or potential claims of discrimination) that may apply to this practitioner
- Is the practitioner a member of a union?

# Additional concerns with an employed practitioner: breach of contract

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## Breach of contract

- if termination of employment is being considered, the termination provisions in the contract should either allow termination without cause, or the “for cause” termination provisions should encompass behavioral issues
- termination for cause may encompass breach of the contract and the contract may require compliance with hospital policies or a code of conduct

# Additional concerns with an employed practitioner: employment liability

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## Federal and state employment laws

- Employment discrimination: can the practitioner claim that s/he is being treated differently because of their race, sex, creed, color, age, disability, pregnancy
- Whistleblower laws: can the practitioner claim that s/he is being retaliated against because they “blew the whistle” on behavior in violation of state law
- Other employment laws include leave laws, workers comp, etc.

# Additional issue with an employed practitioner: discoverability

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Employment investigations and issues are often not privileged and are discoverable unless under the attorney-client privilege

Whereas “peer review” proceedings and minutes may be privileged under state peer review protection laws - but such laws may give protection only against requests for discovery in malpractice cases and not in e.g., anti-trust or other cases by a physician against the hospital or medical staff

# Joint Commission requirements

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Effective January 1, 2009, new Leadership standard LD.03.01.01 addresses disruptive and inappropriate behavior in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors

# Joint Commission requirements

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Medical Staff MS 4.00

Introduces three new concepts as to credentialing and privileging, as developed by ACGME and American Board of Medical Specialties joint initiative

Six core general competencies to be addressed in the credentialing process:

- patient care
- medical/clinical knowledge
- practice-based learning and improvement
- ***interpersonal and communication skills***
- ***professionalism***
- ***system-based practice***

Kaufman Borgeest & Ryan LLP

# Implementation of Joint Commission standards

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How to implement the Joint Commission standards?

Code of conduct

- can include in corporate compliance program and code of conduct
- can include in medical staff bylaws
- can include in employment contracts and standards with which employees must comply

# Implementation of Joint Commission standards

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## Process for managing behavior

- can have a hospital policy
- can have an HR/employment policy
- can include in compliance program
- can include in Medical Staff bylaws

# Coordinate disruptive practitioner policy with Medical Staff Bylaws

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Any policy that affects medical staff members should be coordinated with and consistent with the Medical Staff Bylaws

- are definitions consistent
- when is the practitioner entitled to rights under the Medical Staff bylaws, e.g., to a fair hearing

# Areas requiring coordination of disruptive physician policy with Medical Staff Bylaws

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1. Reporting of an incident or concern with a disruptive physician
  - Medical Staff Bylaws typically limit who may report a concern against a physician that may lead to corrective action under the Medical Staff bylaws
  - whereas disruptive physician policy may allow reporting by anyone
2. To whom is the report submitted
  - Medical Staff Bylaws often require that a report be made to the Chair of the Department or the Medical Executive Committee
  - DR policy may allow reporting to administration

# Areas requiring coordination of disruptive physician policy with Medical Staff bylaws

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## 3. Investigations

- Medical staff bylaws often define who may conduct an investigation that may affect practitioner's privileges
- Medical Staff bylaws may require certain notification to the physician
- Do the bylaws give the practitioner any rights in the event of an investigation, e.g., to appear, to an attorney, etc?

# Areas requiring coordination of disruptive physician policy with Medical Staff bylaws

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4. Results of investigation - If an investigation determines that there has been disruptive behavior, what happens and does that trigger rights under the medical staff bylaws?
  - discussion with practitioner
  - “counseling” of practitioner
  - referral to another body, e.g., psychological evaluation
  - reprimand
  - monitoring of behavior

Does the disruptive physician policy allow certain action to be taken against the physician pursuant to the policy?

- But is that action considered to be “corrective action” under the medical staff bylaws that may entitle the physician to a

hearing before such discipline may be imposed

# Areas requiring coordination of disruptive physician policy and Medical Staff bylaws

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## 5. Summary suspension

Summary suspension is typically allowed under Medical Staff bylaws in the event of “imminent” harm to patients

- and typically requires that the summary suspension be imposed by a limited number of persons
- physician is often given the right to a hearing if the summary suspension continues beyond a prescribed period of time

If the DP policy allows summary suspension, consider how such coordinates with the Medical Staff bylaws in context of (i) basis for suspension, (ii) time period, (iii) persons who may impose summary suspension

- distinguish “employment” suspension from suspension of medical staff privileges

# Areas requiring coordination of disruptive physician policy and Medical Staff bylaws

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## 6. Interplay with Impaired Physician Committee/process

If investigation under Disruptive Practitioner policy results in questions of whether the practitioner may be suffering from an impairment, consider:

- a. Involvement of the Americans with Disabilities Act and other laws prohibiting discrimination against the disabled
- b. Involvement of the process under the Medical Staff bylaws for impaired practitioners

# Coordination of policy and Medical Staff Bylaws

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## 7. Non-physician practitioners

Does policy include non-physician practitioners who may be included under the Medical Staff bylaws?

- e.g. psychologists, nurse practitioners, etc. are often included under “other staff” section of Medical Staff bylaws

Need to coordinate disruptive practitioner policy with this section of the Medical Staff bylaws as well

# Coordination of policy and Medical Staff bylaws

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Consider having the disruptive practitioner policy be preliminary to action under the medical staff bylaws:

- so a report may be made under the DP policy
- investigation may occur under the DP policy
- discussion may occur with the practitioner under the DP policy

All of the above without invoking the medical staff bylaws

But if after discussion with the practitioner, corrective action against the practitioner's privileges is sought, then the corrective action section of the bylaws comes into play and corrective action may be initiated by any person authorized to do so under the bylaws, following the requirements of the bylaws

# Contract with practitioner promising good behavior in future

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## “Contract Imposing Conditions on Continued Practice”

- Agreement by practitioner to:
  - Treat all persons courteously
  - Not engage in intimidating or abusive behavior
  - Refrain from degrading or demeaning comments re hospital or other staff
  - Communicate professionally with staff
  - If have concerns as to how patients are being treated, communicate directly with CMO
  - Compliance monitored by Credentials Comm, MEC, CMO
  - Violations reported to MEC, which may take action, including making recommendations as to privileges
  - Refusal to sign = refusal to meet basic requirements for Medical Staff membership

# CONCLUSION



## QUESTIONS AND ANSWERS

Litigation Issues  
Surrounding Disruptive  
Physicians and Allegations of  
Disruptive Behavior

Robert C. Threlkeld, Partner  
Morris, Manning & Martin, LLP

# Objectives

- Medical Staff and Employment Litigation Issues.
- Whistleblower Protections.
- Patient Risk Management Issues.

# Potential Discrimination Claims by Physicians Accused of Disruptive Behavior

- Claims of Direct Discrimination Under Title VII.
- Claims of Unlawful Retaliation pursuant to 42 U.S.C. § 2000e-3(a), which makes it unlawful for an employer to discriminate against an employee because an employee has opposed a practice that is unlawful under Title VII or made a change, testified, assisted or participated in an investigation or proceeding under Title VII.
- *See Tuli, M.D. v. Brigham & Women's Hospital, Inc.*, 565 F. Supp. 2d 32 (D. Mass. 2008) (granting preliminary injunction against credential committee's requirement that physician consult a physician's health service as condition of re-credentialing, to the extent that recommendation was based on statements of two physicians that exhibited unlawful gender bias under Title VII.)

# Potential Litigation Involving Allegations of Violation of Medical Staff Bylaws

- Litigation involving alleged wrongful revocation, denial, modification of staff privileges.
- Litigation both in jurisdictions that consider the medical staff bylaws to create a contract between a hospital and physician and in those jurisdictions that consider medical staff bylaws as imposing a public or private duty upon a hospital to follow its bylaws even absent a contract.
- Litigation involving wrongful “for cause” termination of employment contract between hospital and physician.

# Peer Review Protections of Healthcare Quality Improvement Act

- Actions of individuals and institutions participating in or assisting with a professional medical review process are generally granted immunity for money damages (not immunity from suit) provided that requirements of 42 U.S.C. § 11111, *et seq.* are met.

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# Peer Review Protections of Healthcare Quality Improvement Act

- For immunity to apply, the professional review action must be taken:
  - (1) in the reasonable belief that the action was in furtherance of quality health care;
  - (2) after a reasonable effort to obtain the facts of the matter;
  - (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and
  - (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3) . . .

42 U.S.C. § 11112(a).

# Illustrative Examples Where Courts Have Found that Standards of HCQIA Were Not Met

- Shudacoff v. University Medical Center of Southern Nevada, 609 F. Supp. 2d 1163 (D. Nev. 2009) (medical center not entitled to immunity where center did not provide physician with prior notice of charges, or opportunity to present evidence or cross-examine witnesses.)
- Clark v. Columbia/HCA Information Services, 25 P. 3d 215 (Nev. 2001) (court held that hospital and individual members of peer review board were not immune under HCQIA where psychiatrist alleged wrongful termination of staff privileges. Psychiatrist had made good faith reporting of perceived improper conduct to outside agencies, and in turn his behavior was challenged as disruptive.)

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# Illustrative Examples Where Courts Have Found that Standards of HCQIA Were Not Met

- Peper v. St. Mary's Hosp. and Medical Center, 207 P.3d 881 (Colo. App. 2008), *cert. denied*, 2009 WL 1383832 (chairman of credential's committee, vice-president for medical affairs, and hospital chief executive officer not immune from suit under HCQIA where cardiovascular surgeon alleged improper termination of privileges for anti-competitive reasons. Court held that immunity did not exist because statutory due process rights under HCQIA were violated.)

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# Illustrative Examples Where Courts Have Found that Standards of HCQIA Were Not Met

- Court noted that due process inquiry is a “classic type of due process inquiry typically left for the courts.”
- In contrast, prongs a(1)(2) & (4) of 42 U.S.C. § 11112 are objective standards applied to professional judgments and are not measured by a subjective good faith standard. Moreover, these standards do not “require that the conclusions reached by the reviewers were in fact correct.” Poliner v. Texas Health Systems, 537 F.3d 368, 378 (5<sup>th</sup> Cir. 2008), *citing* Imperial v. Suburban Hospital Ass’n., 37 F.3d 1026, 1030 (4<sup>th</sup> Cir. 1994)

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# Illustrative Examples Where Courts Have Found that Standards of HCQIA Were Not Met

- Lees v. Asante Health Systems, 2005 U.S. Dist. LEXIS 31729 (D. Ore. 2005) (court denied summary judgment to members of peer review committee under HCQIA where hospital board notified plaintiff that it was revoking her privileges based primarily on physicians allegedly disruptive behavior – which satisfied the requirement that action be taken in furtherance of quality health care, but hospital failed to satisfy second prong requirement of “reasonable effort” to obtain the facts.)

## Illustrative Examples of Peer Review Immunity Granted Under HCQIA in Matters Involving Allegations of Disruptive Conduct

- Wieters v. Roper Hospital, 2003 U.S. App. LEXIS (4<sup>th</sup> Cir. 2003) (peer review community and hospital entitled to immunity where peer review hearing was conducted, physician represented by counsel, and physician placed on probation, required to see psychiatrist and cease disruptive behavior. Court made this holding despite physician's claim that he was a whistleblower respecting alleged substandard care conditions, noting that physician expressed those concerns in a disruptive manner.)

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## Illustrative Examples of Peer Review Immunity Granted Under HCQIA in Matters Involving Allegations of Disruptive Conduct

- Meyers v. Columbia/HCA Healthcare Corp., 341 F.3d 461 (6<sup>th</sup> Cir. 2003) (physician peer review participants and hospital entitled to immunity under HCQIA where members of hospital board conducted an internal review, hearing was held for which physician received adequate notice, and record showed that physician engaged in temper tantrums, coercive behavior, and unethical conduct, even though no medical staff member testified against physician.)

## Other Relevant/Non-HCQIA Cases

- Gekas, M.D. v. Seton Corp., 2008 Tenn. App. LEXIS 197 (court affirmed summary judgment that hospital had not violated bylaws or employment contract where physician was given fair notice of hearing, physician received prior notice of adverse witnesses and expected testimony, and physician participated at hearing. Bylaws required that medical staff member refrain from disruptive conduct, and cooperate with other medical staff members and hospital personnel. There was evidence of disruptive behavior but no evidence of lack of clinical competency.)

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## Other Relevant/Non-HCQIA Cases

- Magrinat v. Trinity Hospital;, 540 N.W.2d 625 (N.D. 1995) (hospital did not violate bylaws in summarily suspending cardiologist who struck hospital employee who refused to proceed with emergent PCI in STEMI patient without open heart back up absent patient consent.

# Best Practices

- Hospital always should follow Bylaws in any action to limit privileges based upon disruptive behavior.
- In the case of summary suspension, care must be given that all hearing rights under Bylaws and Due Process rights under HCQIA are honored.
- Detailed documentation of link between patient care issues and disruptive behavior should be made.
- Bylaws and any employment contract, along with applicable department policies, must address in detail and define without limitation disruptive behavior standards.
- Care must be taken to prefer certain disruptive physicians over others.

# Sample Whistleblower Statutes

- Federal Whistleblower Protection Act, 5 U.S.C. § 2302(b)(8)(A), prohibits the taking of any voluntary personnel action because of “any disclosure of information by an employee or applicant which the employee or applicant reasonably believes evidences – (i) a violation of any law, rule or regulation; or (ii) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public and health safety.”
- *See Greenspan v. Department of Veterans Affairs*, 464 F.3d 1297 (Fed. Cir. 2006) (reversing decision that upheld disciplinary action where physician made “blunt” comments in staff meeting respecting various medical administrative matters.)

# Sample Whistleblower Statutes

- California Whistleblower Protection Act, California Government Code 8547-8547.12 and Section 1278.5 of California Health and Safety Code.
- Retaliatory Discharge Provisions of False Claims Act, 31 U.S.C. § 3729.
- JCAHO Anti-Retaliation Provisions.
- Other State Statutes.
- For Public Hospitals, First and Fourteenth Amendments.

# Risk Management – A Double-Edged Sword

A neurosurgeon was wrestled to the floor by sheriff's deputies outside the operating room after he threw a fit because he had to wait for instruments to be sterilized, authorities say. Deputies believe the surgeon was drunk, and a nurse reported smelling alcohol on his breath. The neurosurgeon took two alcohol breath tests, neither of which showed him to be intoxicated, but the quality of the tests was impaired by the surgeon's lack of cooperation. The doctor had insisted that a trauma patient needed immediate attention and urged staff members to skip the 2-hour procedure to sterilize the equipment, which had been borrowed from another hospital. Two other surgeons, however, had determined that the injuries were not life threatening. The nurse refused to let the surgeon operate, and the outburst ensued. A witness heard the surgeon say, "I am a [expletive] doctor, and I'm going to do what I want." The surgeon threatened the nurse and later took a swing at deputies who were called to intervene. It took three sheriff's deputies to subdue the doctor. The surgeon was arrested and briefly jailed. His hospital privileges were suspended pending investigation by the hospital, the California Medical Board, and the county. The patient had the surgery performed uneventfully the following day.

Pt. Safety & Qual. Healthcare, Jul/Aug 2006.

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# Risk Management – A Double-Edged Sword

Charges against the neurosurgeon who was arrested after verbally and physically threatening behavior at the hospital were dropped by the Alameda County District Attorney's Office. The California Medical Board, which had initially issued a partial suspension of the surgeon's license, has reinstated his license and lists no adverse actions for the surgeon on its Web site. The hospital has reinstated the surgeon's privileges.

Pt. Safety & Qual. Healthcare, Jul/Aug 2006.

# Risk Management Issues

- Questions of Retaliation May Provide Evidence for Claims of Negligent Care By Hospital.
- Failure to Address Sentinel Event of Disruptive Behavior Can Also Expose Hospital to Potential Liability.
- Negligent Credentialing Issues.



December 2, 2008

## Arrogant, Abusive and Disruptive — and a Doctor

By LAURIE TARKAN

It was the middle of the night, and Laura Silverthorn, a nurse at a hospital in Washington, knew her patient was in danger.

The boy had a shunt in his brain to drain fluid, but he was vomiting and had an extreme headache, two signs that the shunt was blocked and fluid was building up. When she paged the on-call resident, who was asleep in the hospital, he told her not to worry.

After a second page, Ms. Silverthorn said, “he became arrogant and said, ‘You don’t know what to look for — you’re not a doctor.’ ”

He ignored her third page, and after another harrowing hour she called the attending physician at home. The child was rushed into surgery.

“He could have died or had serious brain injury,” Ms. Silverthorn said, “but I was treated like a pest for calling in the middle of the night.”

Her experience is borne out by surveys of hospital staff members, who blame badly behaved doctors for low morale, stress and high turnover. (Ms. Silverthorn said she had been brought to tears so many times that she was trying to start her own business and leave nursing.)

Recent studies suggest that such behavior contributes to medical mistakes, preventable complications and even death.

“It is the health care equivalent of road rage,” said Dr. Peter B. Angood, chief patient safety officer at the Joint Commission, the nation’s leading independent hospital accreditation agency.

A survey of health care workers at 102 nonprofit hospitals from 2004 to 2007 found that 67 percent of respondents said they thought there was a link between disruptive behavior and medical mistakes, and 18 percent said they knew of a mistake that occurred because of an

obnoxious doctor. (The author was Dr. Alan Rosenstein, medical director for the West Coast region of VHA Inc., an alliance of nonprofit hospitals.)

Another survey by the Institute for Safe Medication Practices, a nonprofit organization, found that 40 percent of hospital staff members reported having been so intimidated by a doctor that they did not share their concerns about orders for medication that appeared to be incorrect. As a result, 7 percent said they contributed to a medication error.

There are signs, however, that such abusive behavior is less likely to be tolerated. Physicians and nurses say they have seen less of it in the past 5 or 10 years, though it is still a major problem, and the Joint Commission is requiring hospitals to have a written code of conduct and a process for enforcing it.

Still, every nurse has a story about obnoxious doctors. A few say they have ducked scalpels thrown across the operating room by angry surgeons. More frequently, though, they are belittled, insulted or yelled at — often in front of patients and other staff members — and made to feel like the bottom of the food chain. A third of the nurses in Dr. Rosenstein's study were aware of a nurse who had left a hospital because of a disruptive physician.

“The job is tough enough without having to prepare yourself psychologically for a call that you know could very well become abusive,” said Diana J. Mason, editor in chief of *The American Journal of Nursing*.

Laura Sweet, deputy chief of enforcement at the Medical Board of California, described the case of a resident at a University of California hospital who noticed a problem with a fetal monitoring strip on a woman in labor, but didn't call anyone.

“He was afraid to contact the attending physician, who was notorious for yelling and ridiculing the residents,” Ms. Sweet said. The baby died.

Of course, most doctors do not spew insults or intimidate nurses. “Most people are trying to do the best job they can under a high-pressure situation,” said Dr. Joseph M. Heyman, chairman of the trustees of the American Medical Association.

Dr. William A. Norcross, director of a program at the University of California, San Diego, that offers anger management for physicians, agreed. But he added, “About 3 to 4 percent of doctors are disruptive, but that's a big number, and they really gum up the works.” Experts say the leading offenders are specialists in high-pressure fields like neurosurgery, orthopedics and cardiology.

In one instance witnessed by Dr. Angood of the Joint Commission, a nurse called a surgeon to come and verify his next surgical patient and to mark the spot where the operation would be done. The harried surgeon yelled at the nurse to get the patient ready herself. When he showed up late to the operating room, he did not realize the surgery site was mismarked and operated on the wrong part.

“The surgeon then berated the entire team for their error and continued to denigrate them to others, when the error was the surgeon’s because he failed to cooperate in the process,” Dr. Angood said.

A hostile environment erodes cooperation and a sense of commitment to high-quality care, Dr. Angood said, and that increases the risk of medical errors.

“When the wrong surgery is done on patients,” he said, “often there is somebody in that operating room who knew the event was going to occur who did not feel empowered enough to speak up about it.”

Dr. Norcross blamed “the brutal training surgeons get, the long hours, being belittled and ‘pimped’ ” — a term for being bombarded with questions to the point of looking stupid. “That whole structure teaches a disruptive behavior,” he said.

Dr. Norcross and other experts said staff members’ understandable reluctance to challenge a physician, especially a popular surgeon who attracts patients to the hospital, created an atmosphere of tolerance for the bad behavior and indifference. So did a tendency among doctors to form “old boy” networks and protect one another from criticism.

But things have begun to change. Today, good communication and leadership are two of the six core skills taught in medical schools and residency programs. More nurses are challenging doctors on their inappropriate behavior, and fewer hospitals are tolerating disruptive doctors. “Today they’re getting rid of that doctor or sending them to anger management,” said Dr. Thomas R. Russell, executive director of the American College of Surgeons.

Hospitals have also developed more formal and consistent ways of addressing disruptive behavior, Dr. Rosenstein said. They are also trying to improve relations and mutual respect between doctors and nurses.

At John Muir Health, a nonprofit group of two hospitals in Walnut Creek and Concord, Calif., a committee of physicians, nurses and other staff members was formed to focus on collaboration and communication between disciplines.

“When complaints are submitted, we try to be proactive early to let them know there is not going to be any tolerance for that,” said Dr. Roy Kaplan, John Muir’s medical director for quality.

Some physicians worry that hospital administrators will abuse the stricter codes of conduct by using them to get rid of doctors who speak out against hospital policies. And the Joint Commission rulings have spawned a cottage industry of anger management centers and law firms defending hospitals or physicians.

Professionals like Ms. Silverthorn, the nurse in Washington, said the change was overdue.

“We go to school, we have a very important job, but there’s no respect,” she said.

She recalled a particularly humiliating moment on Dec. 25, 2006. Working in the pediatric emergency room, she called a drug by its generic name rather than its brand name.

“I was quickly shouted out of the trauma room and humiliated in front of everyone,” she said. But while “everyone knew the doctor was actually the one who didn’t know what he was doing,” she continued, no one said a word.

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