Disruptive Physicians: Minimizing Liability for Negligent Credentialing, Poor Quality of Care, and Physician Conduct

Practical and Legal Approaches for Hospitals, Integrated Systems, Medical Groups and Other Providers

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Dealing Effectively with Disruptive Behavior to Improve Quality Care

Presented by:

SUSAN F. REYNOLDS, M.D., Ph.D.
President and CEO
The Institute for Medical Leadership
1. What is Disruptive Behavior?
   a. Definition
   b. TJC Zero Tolerance
   c. Causes
   d. Identifying and Dealing with Impairment
   e. Remedies

2. Physician Coaching
   a. Best Coaching Strategies for Improving Disruptive Behavior
   b. Case Study: The Narcissistic Interventionalist
Disruptive Behavior
Professional Code of Conduct

- Conduct that interferes with quality patient care
- Sexual harassment
- Personal attacks on medical staff members or hospital employees
- Vulgar, profane, abusive language
- Physical Assault
- Harsh criticism that belittles, or implies stupidity or incompetence
- Threats of reprisal for reporting disruptive behavior
- Refusal to accept medical staff assignments
- Inappropriate medical record entries concerning quality of care
- Imposing onerous requirements on the nursing staff
- Public criticism or defamation
Classification of Disruptive Behavior

- **Level 1**: Physician violence or other physical abuse directed at people; sexual harassment; weapons on hospital property.

- **Level 2**: Verbal abuse; visual abuse; violence or abuse toward inanimate object.

- **Level 3**: Verbal abuse directed at-large, but perceived to be disruptive.
The Joint Commission

- ZERO Tolerance! – Sentinel Alert July 2008

- “Disruptive Behavior” defined as “behavior(s) that undermine a culture of safety”

- LD 03.10.01 EP 4: Leaders develop a code of conduct that defines acceptable, disruptive, and inappropriate behaviors.”

- LD 03.01.01 EP 5: “Leaders create and implement a process for managing disruptive and inappropriate behaviors.”
CAVEAT:

The term “disruptive physician” can become a stigma greatly impacting a physician’s career, so use with caution.

“Unprofessional behavior” has less of a stigma.
“Seek first to understand, then to be understood.”

Habit #5
“The 7 Habits of Highly Effective People”
Stephen R. Covey
Root Cause of Disruptive Behavior

Identify the problem

Ask why?
Causes of Conflict

- Miscommunication
- Non-communication
- Ego/Personalities
- Cultural Differences
- Disease of Self-Righteousness
- Territorial Disputes/Jealousy
- Different or Unclear Interests/Goals
- Fixed Thinking/Behavior
# Causes of Conflict

- **#1 Cause of conflict** (anywhere, anytime)

LACK OF ACKNOWLEDGMENT!
Causes of Disruptive Behavior

- Divorce
- Financial strain/Payment Reform
- Problems with children or parents
- Practice problems/"Forced Integration"
- Inadequate time off/Burnout
- Substance abuse/Impairment (ACPE < 10%)
- Personality disorder
Causes of Disruptive Behavior

- Why are there more behavioral issues now?

  - Financial strain/Payment Reform
  - Practice problems/"Forced Integration"
  - Inadequate time off/Burnout
  - More awareness: TJC “Zero Tolerance” 2008 and therefore more reporting
Identify Impairment/Burnout

Signs and Symptoms

- Change in behavior or attitude/increased belligerence
- Frequently late to work or sick days
- Poor performance/medical errors
- Increase complaints or lawsuits
- Signs of intoxication on the job
Identify Impairment/Burnout

If impairment suspected or identified

- Refer to Physician Well-Being Committee and follow Physician Well-Being Policy
  - Problem treated medically rather than through disciplinary action
  - Confidentiality
  - Counseling/Rehab/12 Step Program
  - Coordinate with State Program for evaluation and monitoring of practitioner if available and indicated
Other Issues Identified

If danger to patient safety identified

- Refer immediately to person or people designated in Bylaws or Peer Review Policy (Risk Management, Dept. Chair, President of Medical Staff, President/CEO, Physician Well-Being Committee) for immediate action
Other Issues Identified

If possible sexual harassment identified

- Refer to person or people designated in Bylaws, Professional Conduct Policy, or Human Resources Policy (Risk Management, Dept. Chair, President of Medical Staff)
Reporting Disruptive Behavior


- Single occurrence
- Pattern of behavior
- Report goes to Physician Leaders designated in Medical Staff Bylaws, Code of Conduct Policy
- Reporting to State Authorities (get legal counsel)
Reporting Disruptive Behavior


- Date and Time
- Did behavior affect or involve a patient in any way? If so, identify the patient
- Circumstance that precipitated the event
- Factual and objective description of questionable behavior
- Any consequences related to patient care
- Action taken to remedy situation
Remedies
Remedies

FIND THE TRIGGER!

FIX THE TRIGGER

➢ “Informal” cup of coffee intervention
➢ “Awareness” intervention
➢ “Authority intervention
➢ “Disciplinary” intervention
1st Incident: Verbal warning, collegial, educational, coaching.

Further Isolated Incidents: Notification and documentation.

Persistent Problems: Written warning, rehabilitation plan, final warning.

Refer to State program if available and indicated.

Corrective Action and Fair Hearing Plan
Physician Coaching
The Coach

vs.

The Doctor Police
What is Physician Coaching?

One-on-one confidential relationship based on trust

- Identify strengths and weaknesses
- Build on strengths
- Improve or cover weaknesses
Successful Physician Coaching

Key Elements

- Initial buy-in from physician (written contract if possible and appropriate)
- Confidentiality
- One-on-one
- Regular sessions of decreasing frequency
- 6 to 12 month duration – Check-ups to prevent backsliding
- Regular, timely and meaningful feedback (at least monthly)
Best Physician Coaching Strategies

- Listen/Build Rapport/Trust – in person meetings
- Identify cause (impairment/burnout, situational, personality disorder)
- Identify resistance issues (e.g. past training, law suits)
- Resolve Conflict
- Define clear coaching goals and timeline
- Give timely feedback
- Avoid email except for scheduling meetings
- Carrots and Sticks
Listen/Build Rapport/Trust

Matching and Mirroring

- Email
  
  7%

- Voice Mail
  
  7% + 38% = 45%

- In-Person
  
  7% + 38% + 55% = 100%
Case Study:

The Narcissistic Interventionalista
Best Physician Coaching Strategies

Understanding the Alpha Male (HBR May 2004)

- Self-confident and opinionated
- Highly intelligent
- Action oriented
- High performance expectations of himself and others
- Highly disciplined
- Unemotional
Best Physician Coaching Strategies

Coaching the Alpha Male (HBR May 2004)

- Get his attention
- Demand his commitment to the coaching process
- Speak his language
- Hit him hard enough to hurt
  No pain, no gain!
- Engage his curiosity and competitive instincts
Physician Coaching of Disruptive Physicians

Sample Coaching Protocol

- Six to 12 months of coaching
- Get buy-in from disruptive physician
- Weekly meetings for first four weeks (month 1)
- Call a truce for month 1 (ask for no flare ups)
- Biweekly meetings in month 2 if needed
- Quarterly check-ups at 3, 6, 9, and 12 months
- Some telephone coaching possible in between in-person coaching
- If no sustained improvement at 6, 9, or 12 month check-up, refer for formal Peer Review action
Coaching Problems and Pitfalls

- Poor Rapport/No Rapport
- Poor Listening
- Unclear Goals
- Competing Coaches
When to call your attorney

- Call early
- Call often
Thank you!

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Ethical Challenges When Dealing with Potentially Impaired Physicians

Julian Rivera
Overview of Presentation

- Suffering or Disruptive Physicians
  - Case Law, Joint Commission, American Medical Association
- Suffering Physician Turned Impaired Physician
  - ABA Model Rules – Client with Diminished Capacity
  - Integrated Enterprise - Clarity of Who the Client Is
  - ABA Model Rules - Joint Representation
- Practical Communication with Difficult Physicians
Suffering, Disruptive or Impaired?
When is a Physician “Disruptive”?:
Common Law Standards

- Understand what constitutes “disruptive” behavior and what does not.
- History by Case Law - actionable disruptive behavior is characterized by:
  - Objective clear, and convincing documentation of disruptive conduct; and
  - Evidence demonstrating conduct adversely affected patient care.
The Joint Commission ("TJC") Standards and Guidance

- In 2008 TJC issued Sentinel Event Alert “Behaviors that Undermine a Culture of Safety”
- Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and preventable adverse outcomes, increase cost of care and cause qualified clinicians and administrator and managers to seek new positions in more professional environments
- Safety and quality of patient care is dependent on teamwork, communication, and collaborative work environment
The Joint Commission Standards and Guidance

- Intimidating and disruptive behavior include overt actions like verbal outbursts and physician threats.
- Passive actions include refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.
- Intimidating and disruptive behavior in healthcare organizations occurs among physicians and nurses, but also among pharmacists, therapists, support staff, and administrators – across the enterprise.
The Joint Commission Standards and Guidance

- TJC believes disruptive behaviors often go unreported and unaddressed.
- TJC cited an American College of Physician Executives survey which found that 38.9% of respondents agreed that “physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue”
The Joint Commission Standards and Guidance

- TJC implemented new Leadership standard LD.03.01.01
- EP 4: Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety
- EP 5: Leaders create and implement a process for managing behaviors that undermine a culture of safety
The Joint Commission Standards and Guidance

- All team members should be educated on appropriate professional behavior defined by organization’s code of conduct including training in basic business etiquette and people skills
- Code of conduct should be enforced equitably and consistently, regardless of seniority or clinical discipline - transparency
- Implement process for addressing intimidating and disruptive behaviors that solicits and integrates substantial input from all team members
- Implement training to foster collaborative practices
- Implement policies and procedures
The Joint Commission Standards and Guidance

- TJC also suggested implementation of reporting/surveillance system for detecting unprofessional behavior
  - Tiered, non-confrontational, starting with informal conversations
  - Move towards detailed action plans and progressive discipline
- Attempts to address unprofessional behaviors should be documented
American Medical Association ("AMA")
Response and Model Code of Conduct

- In response to TJC’s actions, AMA adopted “Behaviors that Undermine Safety” policy
  - Calls for medical staffs to develop and implement their own code of conduct in medical staff bylaws, and hospital code of conduct applicable to members of board, management and all employees

- AMA Model Code of Conduct for insertion in medical staff bylaws
  - Distinguishes between appropriate, inappropriate, and disruptive behaviors.
American Medical Association Response and Model Code of Conduct

- AMA expressed concern about adequately protecting accused physician’s right to fair process during hospital’s handling of an accusation

- Important to recognize a physician’s perceived disruptive behavior could have been caused by hospital’s own dysfunctional environment of which accused physician himself is a victim

- Concern physician could be sanctioned under guise of disruptive activity for engaging in good faith criticism of an institution or for economic competition with institution
American Medical Association Model Code of Conduct

- AMA Model Code starts with definition of “appropriate behavior” as any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in operations, leadership or activities of organized medical staff, or to engage in professional practice including practice that may be in competition with hospital.
- Appropriate behavior is **not** subject to discipline.
American Medical Association
Model Code of Conduct

- Model Code defines “inappropriate behavior” as conduct that is unwarranted and reasonably interpreted by reasonably prudent person under similar circumstances to be demeaning or offensive.
- Persistent, repeated inappropriate behavior will be subject to treatment as “disruptive behavior.”
American Medical Association Model Code of Conduct

- Model Code defines “disruptive behavior” as any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to extent quality of care or patient safety could be compromised.

- As with Common Law and TJC standards, AMA Model Code requires a connection between offending conduct and patient care.
AMA – Suggested Interventions for Disruptive Physician

- Medical staff support tiered, non-confrontational intervention strategies, starting with informal discussion of matter with appropriate section chief or department chairperson
- Further interventions include an apology addressing problem, letter of admonition, final written warning, or corrective action pursuant to medical staff bylaws
- Use of summary suspension only where disruptive behavior presents imminent danger to health of any individual
AMA – Suggested Interventions for Disruptive Physician

- Complaints should be written and have critical information necessary to well-document and assess complaint including:
  - Date, time and location of offense
  - Factual description of inappropriate or disruptive behavior
  - Circumstances which precipitated incident
  - Identification of any patient or patient’s family member involved in incident
  - Names of incident witnesses
  - Consequences, if any, of inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations
  - Any action taken to intervene in or remedy incident including names of those intervening
Suffering-Disruptive-Impaired Physician Continuum

- Stress and suffering is now across physician spectrum
- Possibility that inappropriate or disruptive behavior is caused by suffering, illness or mental health issue
- Psychiatric clinical conditions such as bipolar disorder, depressive disorders, substance use disorders, or dementia
- Issues can become issues of impairment requiring evaluation and careful management
Impaired Physician – General Definition

- Impaired physician is someone who is unable to practice medicine with reasonable skill and safety as a result of:
  - mental disorder,
  - physical illness or condition, including, but not limited to, those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills, or
  - substance-related disorders including abuse and dependency of drugs and alcohol
Client with Diminished Capacity - ABA Model Rule 1.14

- Client with Diminished Capacity
  - Lawyer shall, **as far as reasonably possible**, maintain a normal client-lawyer relationship with client
  - Take protective action if **risk of substantial harm** unless action taken and client cannot adequately act in client’s own interests
  - **Reasonably necessary protective action**: consulting with individuals or entities that have ability to take action to protect client (can seek guardian)
  - Lawyer impliedly authorized to reveal information about client, but only to extent reasonably necessary to protect client’s interests
ABA Diminished Capacity Guidance

- If risk of substantial harm and normal attorney-client relationship cannot be maintained because of insufficient capacity – protective measures can include consults with family and professional services (“appropriate diagnostician”)

ABA Diminished Capacity Guidance

- Diminished capacity balancing factors:
  - Client’s ability to articulate reasoning
  - Variability of state of mind
  - Ability to appreciate consequences of a decision
  - Substantive fairness of a decision
  - Consistency of a decision with client’s long-term commitments/values

- Lawyer must advocate for least restrictive action on behalf of client
Practical Continuum of Function

- Function Labels – No Simple Definition
  - Engaged and Aware
  - Functional
  - Difficult
  - Dysfunctional
  - Diminished Capacity
  - Impaired
  - Severely Incapacitated
  - Clinically Incompetent

- When is the provider dangerous to the public?
Who is the Client?

- Individual
- Group
- Facility
- System
- Joint Venture
- Medical Staff
- Committee
- Institution
Consider the Governing Documents

- Agreements/Deals/Relationships
  - Provider Agreements
  - Service Line Agreements
  - Joint Ventures
  - Shareholders
  - Bylaws
  - Tertiary Contracts
Joint Representation in the Integrated Enterprise

- ABA Model Rule 1.7:
  - Lawyer should not represent a client if a concurrent conflict of interest exists
  - However, a lawyer may represent a client even if a concurrent conflict of interest exists, if:
    • Competent and diligent representation
    • Not prohibited by law
    • Does not involve assertion of a claim by one client against another client represented by lawyer in the same litigation or other proceeding before a tribunal
    • Each client gives written informed consent
ABA Joint Representation Guidance

- Loyalty and independent judgment essential.
- Resolution of conflict of interest problem requires lawyer to:
  - clearly identify client or clients;
  - determine whether conflict of interest exists;
  - decide whether representation may be undertaken despite existence of conflict, i.e., whether conflict is consentable; and if so -
  - consult with clients affected and obtain informed consent, confirmed in writing.
Practical Communications With Physicians Who Are Suffering

- Proactive and constant vigilance
- Practical functional assessment
- Increase provider’s awareness
- Leverage good business practices:
  - Listening, **Transparency**, Respect, Trust
  - Data Collection
  - Facilitation – Effective Meetings
  - Follow-up – Responsibility
- Leverage reality and practical risks.
Available Resources

- Physician Health Programs
- Forensic Psychiatrists
- Clinical Psychiatrists/Psychologists
- Treatment Centers
- Regulators (e.g. licensing)
- Local Physician Health Programs
- Practice Consultants
- Senior Statesmen/women
- Defense Lawyers
- Physician Coaches
Questions?

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Distinguishing Actionable Disruptive Behavior from Protected Patient Care Advocacy and Implementing Effective Deterrent and Corrective Action Strategies

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Strafford Webinar
Distinguishing Actionable Disruptive Behavior from Patient Care Advocacy

Must be distinguished from a physician who

(i) is merely highly intense or colorful or arrogant by nature,

(ii) criticizes hospital administration or operations, but in a manner that does not harm patient care or hospital operations, or

(iii) is merely advocating strongly (perhaps wrongly but not irrationally) for quality patient care
Distinguishing Actionable Disruptive Behavior from Patient Care Advocacy

- For example (like some other states) 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(c)]
Distinguishing Actionable Disruptive Behavior from Patient Care Advocacy

- Under the California statute, “to advocate for 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(b)]

- Sometimes called “Sham Peer Review”
California law prohibits retaliation against medical staff “whistle blower.”

- Provides for unlimited damages
  - UC Regents paid $10 million in April, 2014 to settle a lawsuit [See Pedowitz v. Univ. of Cal. Bd. Of Regents (Case No. BC 484611)] from a UCLA orthopedic surgeon alleging fellow medical staff members failed to disclose medical industry payments as required by the institution’s conflicts of interest policy.
  - Controversial because could disrupt active peer review proceedings (apparent exception to “exhaustion of administrative remedies requirement) [California Health & Safety Code § 1278.5]
Peer review activities may still be protected from whistleblower actions under certain state laws [See *Lin v. Dignity Health-Methodist Hosp. of Sacramento*, 2014 BL 193117 (E.D. Cal.)]

- Dr. Lin alleged peer review proceedings were initiated against her in retaliation for complaints about another physician’s abandonment of a patient.
- Court concluded that Dr. Lin had failed to make any formal complaints about quality or appear before the medical staff’s judicial review committee.
- Court concluded that hospital’s peer review activities fell within the scope of California’s anti-SLAPP statute and dismissed the case.
According to the California Supreme Court, physicians do not have to exhaust the peer review process prior to filing a whistleblower claim under Section 1278.5 of the California Health and Safety Code. The Court’s decision in Fahlen v. Sutter Central Valley Hosp., 58 Cal. 4th 655 (2014), provides a relevant example.

- The hospital received numerous complaints about Dr. Fahlen’s abusive behavior; Dr. Fahlen in turn complained that nurses failed to follow his instructions.
- The hospital board reversed a JRC determination and terminated Dr. Fahlen’s privileges.
- California’s Supreme Court held that Dr. Fahlen did not have to seek a writ of mandamus seeking to overturn the Board’s determination prior to filing a whistleblower suit.
Medical staffs still must be mindful of when they initiate peer review proceedings or else risk retaliation suits from whistleblowers under Section 1278.5 of the California Health and Safety Code [See Romero v. Cnty. Of Santa Clara, 2014 BL 194997 (N.D. Cal.)]

- Dr. Romero complained about harassment from the hospital’s director of anesthesiology
- Hospital initiated separate peer review proceedings shortly after each complaint from Dr. Romero.
- Dr. Romero’s complaints were protected by the First Amendment and state law.
A willful violation of Section 1278.5 of the California Health and Safety Code is also a criminal misdemeanor punishable by fine up to $20,000

- May eliminate HCQIA immunity too, if facts show corrective action was merely a pretext to remove a physician for complaining about hospital or medical staff problems

- M.D. derives a rebuttable presumption if there is evidence of “whistleblowing” by that M.D. within 120 days prior to date corrective action commenced
Distinguishing Actionable Disruptive Behavior from Patient Care Advocacy

- Similar whistleblower or anti-retaliation law may apply in other states.

  - Privileges revoked for “disruptive behavior” after Dr. Wilkey complained about equipment and scheduling problems
  - 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
Distinguishing Actionable Disruptive Behavior from Patient Care Advocacy

- Impaired Physicians
  - Under the Medical Staff Bylaws, “impaired physicians” are handled separately from other types of disruptive physicians.
    - The Joint Commission requires an ADA-compliant non-disciplinary process (with “reasonable accommodations”) for substance abuse as well as depression and other mental health disorders (under the American Psychiatric Association’s Diagnostic and Statistical Manual – V).
    - ADA and the EEOC mandate “reasonable accommodations” for a “qualified individual” with a “disability,” if the physician can perform all of the essential functions of his or her job. Controversial. Recently some resulting incidents of harm to patients reported in the media.
    - However, 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.
Implementing Effective Deterrent and Corrective Action Strategies

- Joint Committee of Medical Staff and Nursing Staff Leadership (Nurses tend to be unionized, so not really a level playing field)

- Code Of Conduct

- Bylaws
  - Initial Assessment
  - Investigation
  - Documentation
  - Informal Action
  - Formal Meeting
  - Formal Corrective Action
  - Administrative Hearing
Implementing Effective Deterrent and Corrective Action Strategies

- Recommendation: Joint Committee of Medical Staff and Nursing Staff Leadership
  - A Joint Committee of Medical Staff and Nursing Leadership can 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
The costs of inaction are high [See *Nieto v. Kapoor*, 268 F.3d 1208 (10th Cir. 2001)]

- Dr. Kapoor, a medical director in radiation oncology, repeatedly harassed hospital employees and patients using racist and sexist behavior, prompting several hospital employees to quit.

- In filing their § 1983 claim, plaintiffs alleged that Dr. Kapoor created a hostile work environment.

- Court awarded not only $1.875 million in compensatory damages but also $1.875 million in punitive damages.
Implementing Effective Deterrent and Corrective Action Strategies

- Recommendation: Develop a written Code of Conduct signed by all Medical Staff members as a condition of Medical Staff membership
  
  Use and Purpose:
  
  - Require all newly appointed and reappointed medical staff members to sign and agree to comply with the Code of Conduct.
  
  - Establish detailed appropriate behavioral guidelines from the outset.
  
  - 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.
Implementing Effective Deterrent and Corrective Action Strategies

- Recommendation: Update Medical Staff Bylaws
  - Develop expectations of proper behavior and a written policy for enforcing those expectations
  - May cite examples of types of behavior that are disruptive and will be subject to disciplinary action
  - Develop tiers of behavioral severity to ensure greater consistency
    - **Sample Tier 1:** Relatively minor patterns of behavior (e.g., intermittent rudeness to patients and families) would merit a warning or intermediate steps to improve the physician’s behavior.
    - **Sample Tier 2:** A pattern of inappropriate conduct that has a significant adverse impact on patient care and/or hospital operations, after initial clear directives to change that behavior, generally resulting in corrective action.
    - **Sample Tier 3:** Very serious behavioral problems that present an imminent risk to the safety of patients, staff, or others on the hospital premises, whether or not there has been a directive or other warning, generally resulting in summary suspension.
Recommendation: Update Medical Staff Bylaws (cont’d)

- Include specific timelines for investigations and the handling of disruptive behavior by medical staff members

- Continuously educate and update the medical staff on policies regarding disruptive behavior and harassment
Implementing Effective Deterrent and Corrective Action Strategies

- **Recommendation:** Consider using an Independent Review Committee as a strategy for minimizing the risk of whistleblower liability and overcoming uncooperative Medical Staff leadership.
  - Hospital boards have the authority and the duty to initiate corrective actions under the Medical Staff Bylaws if the Medical Staff fails to act when necessary.
  - Developing an independent review committee can serve as an effective system for monitoring patient care activities and actually promote cooperation with the Medical Staff.
Implementing Effective Deterrent and Corrective Action Strategies

- Independent Review Committee (IRC)
  - An independent professional retained by the medical staff office or the board (structured to be privileged under state law) [See Rechsteiner v. Hazelden, 33 Wis. 2d 542 (2008)]
  - Each IRC member should be a licensed medical professional or an unaffiliated hospital administrator.
  - IRC should have the authority to access documents, consult with medical staff members, employees and counsel.
  - IRC should choose their own committee chair, or the appointing body could designate a chair.
Implementing Effective Deterrent and Corrective Action Strategies

- Independent Review Committee (IRC) (cont.)
  - IRC should keep the board chair informed of its work on an ongoing basis and consult with the chair as necessary.
  - IRC members should be compensated by the hospital that demonstrates that compensation is not related to conclusions set forth in IRC reports.
  - The board chair should be authorized to appoint persons to fill vacancies.
  - IRC should be authorized to remain in existence for an initial term (e.g., three to six months) as well as for any extended term approved by the board.
Recommendation: Ensure careful investigation:

- Take appropriate steps to ensure everyone’s confidentiality

- Information should be gathered from as many relevant sources as possible

- Investigation should be done quickly, in days not weeks

- Collect objective factual information regarding the staff member’s behavior
Implementing Effective Deterrent and Corrective Action Strategies

Recommendation: Ensure careful investigation (cont.):

- Avoid subjective opinions regarding the perceived problem
- Avoid making informal medical diagnoses
- Also review any unacceptable prior behavior by the physician
- Review whether there has been any decline in the physician’s clinical performance. (Evidence of a performance problem jeopardizing patient care justifies immediate referral to a medical staff committee to consider appropriate intervention.)
Recommendation: Try to protect peer review activities from discovery.

- **CONCERN:** Some decisions have eroded privileges/immunity from discovery for peer review records. In *Rodas v. Swedish American Health System Corp.* 2007 U.S. Dist. LEXIS 60799 (Ill. N.D., Aug. 20, 2007), quality control reports (same as incident reports) found not protected because no peer review proceeding had commenced when prepared.

- A patient safety incident report was not a part of the peer review process because evidence failed to establish that it was in the hands of a peer review committee. *Orgavanyi v. Henry County Health Ctr.*, 2010 Iowa App. LEXIS 1585 (Iowa Ct. App., Dec. 22, 2010).
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- Recommendation: Try to protect peer review activities from discovery.
  - Incident reports are still privileged in California and most states. *Sutter Davis Hospital v. Sup. Ct.*, 2004 Cal. App. Unpub. LEXIS 8196 (September 8, 2004) is among the state appellate courts that have held that incident reports are privileged peer review documents.
  - In any event, much better to have documented evidence as well as testimony if hearing ensues. The goal is to eliminate offensive behavior, not to punish the M.D. -- except as the last resort.
Recommendation: Documentation should include:

- Date, time, description and circumstances of questionable behavior
  - Including names and positions of those who witnessed or complained about same
- Essential to document the perceived consequences of any of the disruptive behavior as they relate to patient care or hospital operations
Recommendation: Documentation should include (cont.):

- Make a record of any action taken to remedy the situation, including date, time, place, and conduct as well as the names of all those intervening or involved.
- Use non-judgmental language.
- Always refer to the behavior in question, not the person.
- Eliminate any emotionally charged words; use objective descriptions.
- Do not attack the physician’s motives; assume the best intentions.
- Consider range of remedies, from self-correction to coaching to referral to Physician Well-Being Committee or the MEC for referral to outside counseling.
Recommendation: Consider certain informal steps

- Informal Remedies
  - Identify unacceptable conduct
  - Establish a “no tolerance” policy that member should acknowledge in writing (in the Code of Conduct and/or in an individually drafted and tailored separate document at the time of the warning)
  - Create a flexible approach to discipline
  - Administrative discipline does not impose a limitation on the practitioner’s privileges; generally non-reportable to state medical board/NPDB, and therefore does not create a right to a hearing
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If that informal approach doesn’t work... 

- **Formal Meeting**
  - Guidelines for a formal meeting
    - Document the meeting
    - Stay focused on agenda of the meeting
    - Clearly state the violations and the expectations, with citations to the appropriate provisions of the Medical Staff Bylaws, Rules and Regulations
    - Do not send mixed messages
    - Document!
Recommendation: Consider a more formal meeting:

- The Chief of Staff usually should not be involved in an initial informal meeting; if so, that meeting may be deemed to constitute an “investigation” under the Medical Staff Bylaws and prematurely trigger state and federal reporting obligations.

- But repeat offenders should be counseled by, at a minimum, the appropriate Department Chair or the Hospital’s Chief Medical Officer (as well as possibly by the Chief of Staff).

- If informal resolution does not solve the problem, then appropriate disciplinary action should be taken in compliance with the corrective action provisions of the Medical Staff Bylaws.
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- Recommendation: Prepare for administrative hearing
  - Keep the following considerations in mind:
    - Ideally, the Medical Staff will have documented the disruptive behavior immediately with written incident reports and, where appropriate, a behavioral contract signed by the physician
    - Establish the link between disruptive conduct and patient care
    - Use an expert witness (same specialty; not competitor or other antagonist)
    - Focus on the Medical Staff’s prior counseling efforts (let’s hope documented)
    - Provide adequate notice
    - Use the Medical Staff’s attorney to prepare for the hearing (or handle it, if physician insists on being represented by his or her attorney)
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- Recommendation: Prepare for administrative hearing

- Ensure that documentation of a physician’s behavior is available to the peer review body, Smigaj v. Yakima Valley Mem’l Hosp. Ass’n, Case No. 29415-3-III (Wa. Ct. App. 2012).

  - In Smigaj, a peer review committee failed to review and consider all the reports prepared by an external reviewer concerning her disruptive behavior prior to suspending Dr. Smigaj’s privileges.

  - Court held that the Hospital was not entitled to HCQIA immunity, as “a reasonable jury could conclude that Dr. Smigaj has demonstrated....that [Hospital] has not made a reasonable effort to obtain the facts.”
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- Recommendation: Prepare for administrative hearing
  - Consistently apply peer review procedures [See In re Peer Review Action, 749 N.W.2d 822 (Minn. Ct. App. 2008)]
    - Physician accused of recurrent abusive behavior but was only notified of one incident.
    - Peer review committee proceeded to consider suspension before recommending any intermediate steps to help Physician correct his behavior, failing to comply with the hospital’s own disruptive behavior policy.
    - Peer review committee never referred to any specific incident when rendering its decision.
    - Court held in favor of physician finding that the hospital’s actions were motivated by malice.
Recommendation: Consider summary suspension when appropriate

- Summary suspension prior to an administrative hearing is appropriate in rare circumstances where the health or safety of an individual is in imminent danger and the Medical Staff Bylaws threshold standard for summary suspension is met. These may include:
  - Physician accused of recurrent abusive behavior but was only notified of one incident.
    - Physical assault or battery of patients, hospital personnel or other staff members or the public.
    - Conduct that has a serious adverse impact on patient care or hospital operations. The physician is too impaired or is otherwise unsafe to continue to practice in the hospital.
    - Conduct that clearly violates state or federal law or otherwise unreasonably imposes an imminent material risk of legal liability on the hospital.
Bad facts make bad law [See 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.
Bad facts make bad law [See Clark v. Columbia/HCA Information Serv., Inc. 25 P.3d 215 (Nev. 2001)]

- 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
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- But Good Facts Can Make Good Law

  - In this California case, 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. (“Physician exhibited abrasive and disrespectful conduct toward nurses” other staff to the extent they were unwilling to work for him.”)