Dealing with Unprofessional Conduct:

A GUIDE FOR PHYSICIAN LEADERS & HEALTHCARE ORGANIZATIONS

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About the Author

Todd Sagin, M.D., J.D., principal, HG Healthcare Consultants, LLC is nationally recognized for his work with hospital boards, medical staffs, and physician organizations. An independent healthcare consultant, educator, and advisor to the Medical Leadership Institute, he previously served for over half a decade as the vice president & national medical director of The Greeley Company, a division of HCPro.

Dr. Sagin is a popular lecturer, consultant, mediator, and advisor to healthcare organizations. He is frequently asked to assist hospitals and physicians develop strong working relationships in the face of increasing competition and diverging interests. He is board certified in family medicine and geriatrics, and has taught and practiced in both community hospital and university settings. He currently treats uninsured patients at Community Volunteers in Medicine in West Chester, PA.

Throughout his career Dr. Sagin has held strong interests in medical ethics and public policy. He holds a degree in law and has training as a mediator and arbitrator to address healthcare conflicts. Dr. Sagin has also been active in organized medicine at the state and national level. He is a past president of the Pennsylvania Academy of Family Physicians and has served on the Quality Committee and the Credentialing Task Force of the American Academy of Family Physicians (representing over 90,000 of the nation's doctors). He frequently facilitates board and medical staff retreats and delivers leadership education to trustees and physician leaders.

Dr. Sagin can be reached at ToddSagin@comcast.net.

About Our Organization

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Medical Leadership Institute
Toll Free (877) 712-8778
6333 Greenwich Drive • Suite 200
San Diego, CA 92122
MedicalLeadershipInstitute.com

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Introduction

There is no more daunting challenge for a physician leader than addressing the problematic performance of a peer. This task frequently intimidates both new and experienced leaders. Trained in a culture that emphasizes the value of a clinician's autonomy, physicians are inherently reluctant to infringe on that autonomy by exerting leadership control. Nevertheless, addressing inadequate performance is perhaps the most important work that physician leaders undertake. When done successfully, appropriate interventions can:

- Protect patients and assure high-quality care is rendered
- Help colleagues whose misconduct or clinical deficiencies have gotten them into trouble
- Protect institutions from the negative consequences that problematic medical staff members frequently create

This white paper addresses a particular set of "challenging colleagues:" those who engage in unprofessional conduct. A future Medical Leadership Institute publication will describe approaches to help physicians whose clinical skills are deficient and who require remedial intervention.

While this paper focuses on managing *physician* behavior, it is important to note that unprofessional conduct has been widely documented across the full range of health professionals working in hospital settings.

Unprofessional Conduct: The Elephant in the Closet

Unprofessional conduct is widespread in hospitals across America. Largely tolerated over the past half-century, it is no longer acceptable for today's medical staffs. There is a growing body of evidence demonstrating how "disruptive behavior" undermines patient safety and high-quality medical care. Nevertheless, the prime motivation to address inappropriate physician behavior stems largely from two factors: lawsuits brought by aggrieved hospital personnel and the negative impact such behavior has on the recruitment and retention of increasingly scarce nurses and skilled allied health professionals. As a result, hospitals have turned to medical staff leaders and asked them to intervene with their wayward colleagues. The results have been mixed. Most medical staff officers, committee chairs, and department chairs have little formal training in the management of problematic behavior. Faced with a medical staff member who does not welcome efforts to work collegially, many physician leaders feel stymied and frustrated. In the past it has been easier to ignore the outrageous behavior of colleagues than to tackle it directly. But the pressure keeps mounting to end this practice of passivity.

A Common Problem or Much Ado about Nothing?

Human interaction is an important, but largely ignored, source of error.

How common is inappropriate physician conduct? Data to answer this question come from surveys of physician leaders, nurses, hospital staff, and administrators. More than 95 percent of physician executives queried in 2004 by the American College of Physician Executives reported encountering "disturbing, disruptive, and potentially dangerous behaviors on a regular basis."[1] The survey included 1,600 respondents with a third indicating they observed "problems with physician behavior" weekly or monthly. More than half the time, the problematic interaction was with a nurse. The remainder of the incidents involved interactions that were equally divided among other physicians, administrators, or patients and their families.

Nurses report that disruptive physician behavior is the single most important factor with respect to their job morale and satisfaction. Indeed, in a large survey performed by VHA, Inc. at more than 140 hospitals, over one-third of the participants reported knowledge of a nurse leaving an institution because of disruptive behavior by physicians.[2] Sixty-four percent of nurses reported some form of verbal abuse from a physician at least once every two to three months. It is no wonder that studies suggest 18 percent of nurse turnover is directly attributed to verbal abuse. Twenty-three percent of nurses reported at least one instance of physical threat from a physician (most commonly a thrown object).[3]

Seventy-five percent of physicians reported having observed inappropriate conduct on the part of a colleague. Of note however, is that they also indicated they rarely intervened. Many reported they have seen a patient put in harm's way as a result—this is particularly troubling.

Does "Disruptive Conduct" Affect Patient Safety and Quality of Care?

Many industries have begun to acknowledge that human interaction is an important, but largely ignored, source of error. The airline industry has been a pioneer in this respect, and "crew resource management" is a safety approach being promulgated in many workplaces.[4, 5] In healthcare settings, the importance of the connection between the interactions of "team" members and safety/quality is just surfacing.

The Institute for Safe Medication Practices (ISMP) surveyed more than 2,000 health professionals in November 2003. It found that 7 percent of respondents indicated that they were involved in a medication error during the past year, in which intimidation clearly played a role. To quote from the ISMP press release:

> **"Almost half of all respondents (49%) indicated that past experiences with intimidation altered the way they handle order clarification or questions about medication orders. At least once in the past year, about 40% of all respondents who had concerns about the safety of a medication assumed that it was correct rather than interact with an intimidating prescriber. Even when the prescriber was questioned about safety, almost half (49%) of respondents felt pressured into dispensing a product or administering a medication despite their concerns…. Almost half of respondents reported being the recipients of strong verbal abuse (48%) or threatening body language (43%) at least once during the last year."[6]**

Disruptive behavior affects quality of care when it causes nursing or other staff shortages in the hospital setting, when it disrupts

1 David O. Weber, "Poll Results: Doctors' Disruptive Behavior Disturbs Physician Leaders," *Physician Executive*, September/October 2004; p. 6.

2 Alan H. Rosenstein, Henry Russell, and Richard Lauve, "Disruptive physician behavior contributes to nursing shortage: study links bad behavior by doctors to nurses leaving the profession – Doctors, Nurses, and Disruptive Behavior," *Physician Executive*, November/December, 2002.

3 Alan H. Rosenstein, "Nurse–Physician Relationships: Impact on Nurse Satisfaction and Retention," *American Journal of Nursing*, June 2002, Vol. 102, No. 6; pp. 26–34.

4 F. Andrew Gaffney, M.D., FACC, Captain Stephen W. Harden, and Rhea Seddon, M.D., *Crew Resource Management*: *The Flight Plan for Lasting Change in Patient Safety*, HC Pro, Inc., 2005.

5 For a discussion of crew resource management's applicability to medicine, see Laura Pizzi, Pharm.D., Neil I. Goldfarb, David B. Nash, M.D., M.B.A., "Chapter 44. Crew Resource Management and its Applications in Medicine," in *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*, AHRQ, July 20, 2001, available at www.ahrq.gov/clinic/ptsafety/chap44.htm.

6 The Institute for Safe Medication Practices' press release from March 31, 2004 can be found at www.ismp.org/pressroom/pr20040331.pdf.

the smooth collaboration of a clinical team, or when it creates a hostile workplace environment that distracts employees from their focus on patient care. Nurses who are verbally abused report that it undermines self-confidence and lowers self-esteem. One study has found that 18 percent of nurse turnover is directly related to such verbal abuse.[7] Responding to inappropriate conduct also consumes the time of physician leaders, management, human resources personnel, nurse supervisors, and others. The efforts of these people could otherwise be directed at more direct patient care needs.

7 H. C. Cox, "Verbal abuse in nursing: Report of a study," *Nursing Management*, Volume 18(12), December 1987; pp. 47–50.

What Is "Disruptive Behavior" or "Unprofessional Conduct?"

The AMA describes "disruptive conduct" as follows:

> **"personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively."**[8]

The range of unprofessional conduct manifested in healthcare settings is unsettlingly broad (see sidebar: Manifestations of Unprofessional Conduct). Newspaper stories tell of doctors who have walked out in the middle of surgery to run personal errands, fist fights in the doctors' lounge, and a nurse locked in a closet by an angry physician! Staff members relate episodes of verbal abuse, demeaning demands, sexual harassment, thrown objects, and shocking temper tantrums. Physicians tell of colleagues who obstruct constructive dialogue at medical staff meetings, chart inappropriate comments in medical records, and threaten retaliation when not given their way.

Harassment, a frequent form of inappropriate conduct, can relate to an individual's race, age, religion, color, sex, sexual orientation, national origin, ancestry, marital status, and mental or physical disability. Some hospital policies define harassment as *any form of physical or verbal abuse of such significant character and nature that no person of reasonable sensitivities should be expected to tolerate.*

The concept of disruptive behavior takes into consideration physician actions that create a hostile workplace environment; damage the reputation of the hospital and its medical staff; cause a disproportionate expenditure of time, resources, and money; or increase the likelihood of malpractice or other tort or regulatory liability exposure.

Manifestations of Unprofessional Conduct

- Disrespectful, profane, demeaning, or rude language
- Sexually inappropriate speech
- Sexual boundary violations/inappropriate touching
- Intimidation
- Harassment
- Racial/ethnic innuendo or insults
- Throwing tirades and outbursts of anger
- Throwing objects such as instruments or charts
- Criticizing other caregivers in front of patients or other staff
- Comments that undermine a patient's trust in other caregivers or the hospital
- Repeated, intentional non-compliance with organization rules and policies
- Deliberate interference with the smooth functioning of hospital or medical staff operations
- Inappropriate comments in the medical record—especially those impugning the quality of the work done by others
- Unethical/dishonest behavior
- Repeated lack of response to calls from other health personnel
- Unwillingness to work collaboratively
- Inappropriate arguments with patients, their families, hospital staff, or other physicians
- Retaliation against any member of the healthcare team who reports a conduct violation or impropriety
- Failure to adequately address a safety concern or patient care need expressed by another member of the healthcare team
- Non-constructive criticism, especially when expressed to the recipient in an intimidating manner and/or in a manner that undermines confidence, is belittling, or implies stupidity or incompetence
- Imposition of idiosyncratic requirements on members of the hospital staff that have nothing to do with providing quality patient care
- Inappropriate use of litigation or threats of litigation

8 AMA Policy H-140.918.

Without a doubt, the life of a professional in medicine today is enormously stressful. Physicians receiving counseling for disruptive behavior frequently cite pressures in their personal and professional lives as the cause of their misconduct. Yet it is the very essence of professionalism to act appropriately, even under trying conditions.

Why Is Unprofessional Conduct So Prevalent?

There are more than 800,000 practicing physicians in the United States and only a minor percentage demonstrates a pattern of inappropriate behavior.[9] This still amounts to tens of thousands of physicians whose conduct is regularly problematic. A *small* number of disruptive physicians suffer from underlying illness. Many observers of physician misconduct assume that it indicates an underlying substance abuse problem with drugs or alcohol. However, it is estimated that substance abuse accounts for less than 10 percent of physician behavior problems.[10] Likewise, few of these troubling practitioners have a major psychiatric illness (although personality disorders may be frequent).

A predisposing factor for problematic physician conduct is the strong emphasis medical education puts on professional autonomy. The culture of autonomy tends to be dismissive of authority and often sees "leadership" as illegitimate. This culture fosters resistance to rules, requirements, and the authority of administrators and medical staff officers.

In addition, this 'culture of the expert' gives physicians a unique perspective regarding "teamwork." Whereas most hospital staff members see teamwork as the close coordination and collaboration of a group of individuals, doctors often see teamwork as individuals smartly responsive to the physician "captain of the ship." Medical education trains physicians and nurses in an outdated, "hierarchical" model that makes the latter subservient to the former rather than equal participants on a team where everyone brings unique skills. Unfortunately, this archaic aspect of physician training also sets the stage for disruptive behavior.

The hierarchical model of physician training sets the stage for disruptive behavior.

Some observers believe that a rise in unprofessional conduct has coincided with the growing demoralization of medical practitioners. Physicians, who are beleaguered by malpractice suits, increasing time demands, declining prestige, increased scrutiny of their clinical decisions, an onslaught of regulations and paperwork, and diminishing incomes, are increasingly dispirited—and some adopt a victim mentality. When in this mindset, they are more likely to lash out at the closest or most vulnerable targets—those often being hospital staff members.

However, the most likely reason unprofessional behavior is so prevalent is because, for decades, *healthcare organizations have simply tolerated it.* In years past, physicians were afforded unconditional regard that let them get away with behavior others could not. Their key role as revenue generators for hospitals sometimes made them untouchable.[11] And the profession did not rein in its own because physicians have always been reluctant to confront colleagues and have been quick to excuse problematic behavior in deference to productivity and clinical competence. The result at many hospitals is a culture that overlooks all but the most abusive behavior.

9 One review suggests the number of disruptive physicians is between 3 and 5 percent (Leape and Fromson, "Problem Doctors: Is There a System-Level Solution?," *Annals of Internal Medicine*, Vol. 144, 2006; p.108).

10 Weber, 2004; p. 7.

11 The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the 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." (T. Keogh, and W. Martin, "Managing unmanageable physicians," *Physician Executive*, September/October 2004; pp. 18–22.)

Changing Expectations: The Move to Zero Tolerance

Clearly, physician behavior tolerated in the last century will not be tolerated in 21st century healthcare institutions. Perhaps the clearest marker of this change in attitude was the issuance of a Sentinel Event Alert by The Joint Commission on July 9, 2008.[12] The alert noted that there has been a "history of tolerance of and indifference to intimidating and disruptive behavior in healthcare" and it asserted that organizations that fail to address such behaviors through effective systems are, in effect, indirectly promoting it. The alert observed that disruptive behavior in the hospital setting can lead to:

- Medical error
- Decreased patient satisfaction
- High staff turnover
- Preventable adverse outcomes
- Increased cost of care

The Joint Commission alert also pointed out that patients and their families readily recognize hostility in the workplace, even when it is not directed at them. This can lead to patient dissatisfaction with the professionalism of the healthcare team, and increase the likelihood of a malpractice action. Reflecting the building sentiment of our time, the alert commented that, "All intimidating and disruptive behaviors are unprofessional and should not be tolerated." In the wake of The Joint Commission Sentinel Alert, many organizations have undertaken reviews of their policies and procedures and the effectiveness of their implementation.

Joint Commission Standards on Disruptive Behavior

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership Standard *(LD.03.01.01)* that addresses disruptive and inappropriate behaviors in two of its elements of performance (EPs):

- 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.

In this age of information, news of egregious episodes of unprofessional behavior often appears in the press, on the Internet, in healthcare blogs, and through the ever-present rumor mill. The entire medical profession is diminished when these stories come to light. Public antipathy for unprofessional physician behavior is unqualified. Plaintiff malpractice attorneys look for evidence of disruptive conduct in the backgrounds of physicians they are suing. They perceive it as a clear way to win a jury's sympathies.

Another manifestation of a growing intolerance for misconduct can be discerned in the recent push by private insurance companies and governments to deny reimbursements for so-called "never events." These are clinical occurrences that payers have determined are unreasonable. Much of the literature on never events suggests that they occur more frequently where there is poor communication, collaboration, and teamwork. These elements of essential good care are all undermined by the behaviors attributed to disruptive practitioners.

Reporting of Disruptive Behavior

It is difficult for an organization to respond effectively to unprofessional conduct if it does not know if and when it is occurring. Healthcare institutions should have clear policies regarding the reporting of conduct concerns. In many hospitals, staff members frequently fail to use reporting mechanisms. Their reasons include fear of retaliation, reluctance to confront or be confronted by an intimidator, and the stigma associated with "informing" on a colleague. In addition, many who observe disruptive behavior in hospital settings do not report it simply because they do not believe the report will result in any significant effort to address the situation. These attitudes are all inimical to a culture of excellence.[13]

Some institutions address staff reluctance to identify disruptive incidents by allowing reports to be submitted anonymously. This approach removes a significant barrier to learning about inappropriate conduct that puts patients, staff, and the hospital at risk. It is very likely that a higher percentage of incidents will be reported under a system that guarantees anonymity.

Nevertheless, some staff members will still hesitate to report because the particular circumstances of the incident reported may well give away their identity. Anonymous reporting also makes it more difficult to investigate a complaint and assess its validity. This in turn makes it more difficult for physician leaders to know whether there is a legitimate or serious problem with the conduct of a colleague. For example, under an anonymous reporting system, multiple complaints may come from a single staff member and represent a personal feud rather than impartial reports of recurring problematic behavior.

Many institutions require that complaints about unprofessional conduct be signed so that appropriate follow-up can occur with the individual submitting the report. Where this is the policy, it is important for hospital and medical staff leaders to strictly enforce a position that bars any type of retaliation. Any breach of this stance will significantly undermine the reporting process. A culture of safety is one where staff members feel secure and supported in pointing out circumstances that threaten patient or personal well being. Institutions should consider putting non-retaliation provisions in their policies on professional conduct, in employment agreements, and in medical staff bylaws.

Individuals who report conduct violations often demand information on how their complaint has been addressed. When staff members believe their reports have no impact on abusive behavior, they are likely to stop submitting them. It is important, therefore, to close the loop with staff members when reporting is not anonymous. The reporter(s) should be told that any intervention carried out with the offending doctor is part of a protected peer review process, the details of which are confidential. Nevertheless, the reporter(s) should be informed that their concerns have been heard and investigated and that actions in accordance with the medical staff conduct policy are being undertaken. While this won't satisfy everyone, it will make

12 "Behaviors that undermine a culture of safety," Sentinel Event Alert, Issue 40, The Joint Commission, July 9, 2008, available at www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm.

13 Rosenstein, 2002.

clear that the hospital has taken the report seriously and has not turned a blind eye to staff concerns.

Creating a Culture of Zero Tolerance: Stopping Disruptive Behavior before It Occurs

When confronted with concerns about their problematic behavior, many physicians are surprised to hear that their conduct is not acceptable. In some cases they have been engaged in the behavior for years and no one has ever confronted them with its inappropriateness. In part, these physicians have been disruptive because no one ever told them they had to stop. It is not an uncommon scenario for a physician leader to confront a colleague about the use of "foul" language in a critical care unit, only to be told by the offender in reassuring tones: "No need to worry, I've been talking that way for years and nobody minds!"

Setting clear behavioral expectations is the first step to creating a culture in which disruptive behavior is rare. If an organization does not lay out the "ground rules," it is not reasonable to expect everyone will know what they are. If a hospital wants to enforce certain behavioral expectations, it should make them absolutely clear to those who work there.

If a hospital has a history of overlooking problematic behavior, it is particularly important that it lay out its new expectations going forward and put everyone on notice that its stance has changed.

How should a hospital convey its requirements for appropriate staff conduct? The Joint Commission's new Leadership Standards require accredited hospitals to have a "code of conduct that defines acceptable and disruptive and inappropriate behaviors." Such codes of conduct, while far from universal, have been employed by many hospitals for decades. Putting a code of conduct in place makes explicit exactly what is considered unacceptable behavior at the institution. While some organizations have very general conduct codes that are applicable to the entire hospital community, it is often prudent to have a specific document that addresses physicians. This is because many physicians, particularly if in private practice, have not felt constrained by policies they believe are directed at employees. Having a code of conduct for medical staff physicians makes it abundantly clear to whom it applies.

When composing a code of conduct, it is important to describe unacceptable behaviors both generally and specifically. For example, this document might state that "all clinical practitioners/medical staff members will treat colleagues, hospital staff, patients, and their families in a respectful and dignified manner at all times, irrespective of the circumstances." While this is an important statement to make in a code of conduct, it does not provide enough specific guidance regarding particular behaviors that are considered out of bounds. The best documents will articulate an extensive (but not exhaustive) list of behaviors considered to be inappropriate. (Examples of items that might comprise that list can be found in the sidebar entitled Manifestations of Unprofessional Conduct on page 5.) The more complete the list, the less room there is for a wayward physician to argue that the actual behavior she engaged in was acceptable.

While it is important to define behavioral expectations, this effort is of little value if the expectations are not effectively communicated to the target audience. If a code of conduct is in place, it should not be "out of sight and out of mind." This document might be included in an application package for medical staff membership, part of a welcome package or orientation program when a new physician joins the staff, and inserted into reapplication materials. Many hospitals ask that physicians sign the code of conduct at these times to acknowledge receipt. Many institutions will post copies of the code in the doctor's lounge, dining room, OR locker room, or the medical staff Web site. If the prevalence of problem behavior warrants it, the code of conduct may be periodically reviewed at general medical staff meetings.

Another way to keep the importance of appropriate conduct in the minds of physicians is to address compliance in periodic performance feedback reports. Such reports should now be routine at most hospitals and are part of the "ongoing professional practice evaluation" required by The Joint Commission. These reports can indicate whether there has been complete compliance with the conduct code or whether the recipient has failed to meet expectations. Feedback reports often provide information on numbers of validated complaints received about a physician, delinquencies in medical record completion, responsiveness to pages, and so forth. All of these can be considered measures of professionalism and help reinforce the importance the medical staff places on appropriate conduct.

Some hospitals use a 360-degree assessment tool to provide doctors insight into how they are perceived by others. Such tools have long been used in the corporate world, but only recently in medicine. This tactic gathers the input of patients, nurses, OR personnel, receptionists, physician colleagues, department chairs, and so forth, to provide feedback to a physician regarding both clinical performance and professionalism. The assessment tool is easy to complete and often asks respondents to rank the physician's performance compared to other doctors they observe. The value of a 360-degree assessment is its ability to uncover difficulties with interpersonal communication and unprofessional conduct that may not have generated specific documented complaints. It can provide an early alert to the physician and to medical staff leaders that a problem is brewing.[14]

Formal Compacts

In some communities, hospitals and medical staff members have been negotiating a formal "compact" or understanding of their mutual responsibilities.[15] These efforts are intended to clarify reasonable citizenship obligations hospitals can expect from community doctors, and what the hospital will provide them in return. Many of these compacts explicitly address the expectation that physicians will comply with established codes of conduct. All members of the staff are expected to sign the compact and adhere to its understandings.

14 M. Lazoritz, "Coaching for Insight: A Tool for Dealing with Disruptive Physician Behavior," *Physician Executive*, January/February 2008; pp. 28–31.

15 J. Silversin and M. Kornacki, *Leading Physicians Through Change: How to Achieve and Sustain Results*, American College of Physician Executives, September 2000; p. 45.

An increasing number of medical staff physicians are also employees of hospitals. Behavioral expectations should be explicitly addressed in employment contracts of these practitioners. A review of the conduct code and requirements for compliance should also be part of the regular formal performance reviews of employed staff members. It is hard to overdo reinforcement of these professional standards.

A formal code of conduct is not the only way to express performance expectations. Consider the following effective measures:

- Language in the medical staff bylaws should clearly establish the responsibility of every medical staff member to behave professionally at all times.
- The bylaws should make clear that professional conduct will be considered when evaluating applicants to the medical staff and when evaluating their appropriateness for reappointment once on staff.
- Medical staff governing documents should indicate that applicants and medical staff members will be required to undergo professional behavioral evaluations when medical staff leaders feel such are necessary.
- The bylaws should include a mandatory appearance clause that requires a medical staff member to come before a medical staff committee or officer when requested to explain unprofessional conduct.

Institutions that have thoroughly indoctrinated their practice community about appropriate behavior often evolve a culture in which enforcement becomes a subtle and natural process of collegial peer pressure. In these settings, both physicians and nurses feel comfortable pointing out to their fellows when behavior steps over the line. There typically is less need to wait for someone with formal authority to intervene. Of course, the greatest benefit of setting and communicating clear expectations is that most practitioners will self-police their own behavior. In such a culture, the concept of taking disciplinary action against a physician rarely comes into play.

Code of Conduct Policy

The typical medical staff conduct policy will contain several elements:

- The standard for professional behavior (usually the code of conduct)
- The reporting mechanism(s) for those who observe violations
- The process for investigating allegations of misconduct
- The collegial steps that will be taken to address confirmed violations of the conduct code
- The individuals authorized to undertake these collegial steps
- The progression of interventions that can lead up to formal corrective action

The policy makes clear how the organization will proceed when violations of the code of conduct occur. Awareness of the consequences may forestall misbehavior on the part of some practitioners. Some codes of conduct explicitly describe behaviors that are deemed "appropriate" for physicians wishing to express concerns about patient safety and quality. An example can be found in the sample code of conduct made available from the organized medical staff section of the American Medical Association Web site (www.ama-assn.org) in March 2009.

The policy is also a valuable risk management tool because it assures that unprofessional behavior is not dealt with in an arbitrary and inconsistent manner. It provides clear guidance to medical staff leaders who may not have experience working with disruptive colleagues. *It is always worth remembering that physician leaders should be trying to help good doctors avoid doing harm to themselves through inappropriate behavior* (see sidebar: Personal Consequences of Disruptive Behavior).

First and foremost, the conduct policy should be a roadmap for achieving this goal while protecting patients, staff, and the institution.

Consequences

Once an institution has made its conduct expectations clear, it is also important to put practitioners on notice regarding the consequences of non-compliance. These are usually spelled out in specific hospital and medical staff policies. The medical staff's disruptive physician conduct policy (or equivalent) should clearly state who has authority to enforce the institution's code of conduct. Typically named are the medical staff officers, department chairs, vice president of medical affairs, and hospital CEO. Additionally, some policies will name the chairman of the medical staff peer review committee, physician wellness committee, and/or physician conduct committee.

Personal Consequences of Engaging in Disruptive Behavior

- Isolation from colleagues
- Decreased social network
- Heightened personal stress; depression
- Increased workload because colleagues will not assist
- Potential loss of privileges, license, and employment
- Increased risk of lawsuits from disgruntled patients, family, and staff
- Difficulty finding future employment, hospital privileges, and patients

Minding the Gate: The Role of Credentialing in the Prevention of Unprofessional Conduct

It is often observed that the best predictor of future behavior is past behavior. The best way to assure that disruptive behavior rarely occurs among a hospital's physicians is to screen for it in the vetting of new candidates for the medical staff. The following are key components of an effective vetting process:

- Applications should specifically ask if an applicant has ever been given a formal warning, reprimand, or been put on probation for unprofessional conduct.
- The medical staff bylaws should clearly state that the omission of significant information on the application is grounds for immediate loss of privileges and membership.
- The National Practitioner Data Bank should be queried and the results reviewed for evidence of professional misconduct.
- References should be specifically asked about their personal knowledge regarding the professional conduct of the applicant.
- If the written reference hints at anything less than good professional behavior, the author should receive a call from a medical staff leader to probe further.

A note about personal references: Hospitals should routinely ask applicants to the medical staff for references from those who can comment on the physician's professional conduct. If the credentials committee is aware of a setting in which unprofessional behavior is alleged to have occurred, it should request information from specific individuals who would be likely to have direct knowledge of such misconduct. It should be the applicant's responsibility to see that these references are completed and until they are returned, the application should be considered incomplete.

Clearly this is a time when an ounce of prevention is worth a pound of cure.

Disruptive practitioners often intimidate those a hospital seeks as references with threats of lawsuits for defamation or tortious interference with their business prospects. These are clear attempts to muzzle communication of previous problems. Even when no overt threats are made, those who are asked to provide information about applicants from their first-hand knowledge are often well aware of the litigious temperament of the individual about whom they are being asked to comment. When former employers, hospital personnel, medical staff representatives, or personal acquaintances appear reluctant to speak on the record about behavioral concerns regarding a physician applying for staff privileges, the applicant should be asked to provide a specific release assuring he will bring no legal action if these individuals are forthcoming with information. *In the event such a release is not executed, no further processing of the medical staff application should take place.*

Interviews of potential new medical staff members can sometimes be helpful in revealing problem personalities. An applicant might be asked what the proper response is from a nurse who observes inappropriate physician conduct in the hospital. Failure of the applicant to acknowledge the reality of disruptive conduct or to concede the importance of reporting its existence should be a red flag to a careful credentials committee. In general, practitioners "who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior."[16]

Frequent Characteristics of Disruptive Physicians

- They believe they are always right
- They believe they are not subject to rules established by others
- They view those with authority as fools or ill-intentioned individuals
- They don't respect "organizations" or lines of authority
- They are often self-described "champions of quality"
- They often have a volatile personality or are passive/aggressive in nature
- They immediately and strenuously attack others when criticized
- They are quick to threaten retaliation or bring lawsuits
- They can be charismatic—but are poor team players

Several studies have noted that evidence of a predilection for disruptive conduct often surfaces during medical training. In one case-control study, disciplinary action taken against physicians by medical boards was closely correlated with unprofessional behavior exhibited by those physicians in medical school.[17] Medical students who were described as irresponsible or as having diminished capacity for self-improvement were the most likely to be disciplined later by a medical board.

Another retrospective study showed evidence that poor performance on behavioral and cognitive measures during residency are associated with greater risk for state licensing board actions against practicing physicians.[18]

A 2008 article in the *Journal of the American Medical Association* noted, "Educators have been criticized for not teaching and rigorously assessing the core values of medicine that

16 Sentinel Event Alert, Issue 40, The Joint Commission, July 9, 2008.

17 M. Papadakis, et al., "Disciplinary Action by Medical Boards and Prior Behavior in Medical School," *New England Journal of Medicine*, Vol. 353, No. 25, December 22, 2005; pp. 2673–2682.

18 M., Papadakis, et al., "Performance during Internal Medicine Residency Training and Frequent Disciplinary Action by State Licensing Boards," *Annals of Internal Medicine*, Vol. 148, No. 11, June 3, 2008; pp. 869–876.

19 D. Reed, C. West, P. Mueller, R. Ficalora, G. Engstler, T. Beckman, "Behaviors of Highly Professional Resident Physicians," *Journal of the American Medical Association*, Vol. 300, No. 11, Sept. 17, 2008; pp. 1326–1333.

determine professionalism."[19] The authors went on to describe measurements that can be used in residency training to assess various parameters of professionalism. A growing body of research suggests that it is valuable for credentials committees to query the educational background of medical staff applicants to determine if antecedents to disruptive conduct were manifest during their training.

When there is a concern: credentials committees often dismiss vague red flags of applicant misconduct on the grounds that they are "hearsay" and unsubstantiated. They too quickly assume they cannot obtain more definitive information about past unprofessional behavior. This has often led to the appointment of a potentially problematic physician even when medical staff leaders harbor serious reservations about that individual.

A good credentials committee will remember that the burden is on the applicant to resolve doubts regarding her qualifications for medical staff membership. This individual can be asked to submit additional references to help dispel concerns. For example, when rumors reach the committee that a new surgeon applicant has been disruptive in operating rooms elsewhere, the following could be required: submission of three additional letters of reference from the OR director, chair of surgery, and VPMA at the last hospital where the surgeon practiced regularly. The references could be asked to answer specific questions such as: Has this physician had problematic working relationships with staff at your institution? Ever been disciplined or received a reprimand or warning for unprofessional conduct? Ever been disruptive in the operating room setting? Ever been the subject of an investigation for inappropriate behavior? The credentials committee would make clear to the applicant that it must receive these completed reference questionnaires before any further processing of her request for membership can occur.

The burden is on the applicant to resolve doubts regarding her qualifications for medical staff membership.

When a committee has serious concerns about the potential for an applicant to become a conduct problem, it might also request that the individual undergo a formal evaluation. There are specialists and organizations around the country that focus on the assessment of behavioral problems in professionals (see sidebar on page 15). If concerns continue to exist, the hospital board has the option to grant an applicant a conditional appointment—one in which professional behavior will be closely monitored and code-of-conduct violations become grounds for immediate dismissal. However, once on the staff, the physician will be entitled to full due process before a termination can be completed.

Credentials committees should effectively vet applications and be diligent in looking for evidence of unprofessional conduct in the backgrounds of those wishing to join the medical staff. Once an institution lets a disruptive practitioner on its staff, the pain of dealing with the consequences is usually significant!

Confronting Disruptive Physician Conduct

Regardless of how assiduously an organization communicates behavioral expectations, almost always someone will fail to comply. As indicated earlier, many organizations have long histories of neglect when it comes to confronting violators. In a survey of physician executives, more than two-thirds of the respondents reported that their organizations had codes of conduct in place, but less than 50 percent felt they were effective.[20] The reason these tools are viewed as ineffective by so many hospital staff members and physicians is because they are *rarely enforced*.[21]

While external pressures may be forcing hospitals to pay more attention to enforcement, most medical staff leaders are ill-prepared to deal with disruptive colleagues. Ultimately, trust in the leadership of the medical staff and hospital is undermined when obviously dysfunctional and unprofessional behavior is tolerated. In the absence of specific training in the management of problematic physician performance (behavioral or clinical), it should be no surprise that little effective intervention is accomplished.

Every hospital should have a development plan to train effective current and future medical staff officers and chairs. Many health systems have initiated leadership academies to provide such training, send new medical staff leaders to offsite educational programs, enroll in membership support programs, or create an ongoing, onsite lecture series built around leadership curriculums.

There are also growing numbers of physician executives in VPMA and CMO positions who have both experience and explicit training in the management of disruptive physician behavior. These executives can mentor rotating medical staff leaders who are new in their roles and can help guide them in their interactions with disruptive colleagues. Often these individuals take the lead in the management of inappropriate physician behavior.

An episode of disruptive conduct should be addressed with the physician as soon as the incident is reported. The nature of the intervention will vary according to the severity of the violation. For example, an isolated occasion of inappropriate criticism may be addressed with a polite, but firm, written reminder of the behavioral expectations everyone has agreed to uphold. But if the violation involves physical intimidation, it will require a more definitive intervention. In this case, the offender might be called to the office of the medical staff president or hospital VPMA to hear, in person, a clear description of the very significant consequences that will result from any repetition.

Some organizations create a tiered ranking system to indicate the severity of conduct violations.[22] Each level (e.g., Level I, II, or III) is used to describe varying degrees of problematic behavior and the subsequent response from the organization. The most egregious level might require response in twenty-four hours, the next level down might allow five days, and so forth. This approach provides some structure to responses and promotes uniformity in the way certain violations are addressed.

It is advisable to have a third party present when talking to a disruptive physician about offending behavior.

Confronting a disruptive colleague is always stressful and challenging. Physician leaders who do not have extensive experience in this activity should consider practicing in advance by role-modeling an encounter with a mentor or trusted friend. Such rehearsal can enable the less experienced leader to weather with equanimity the likely emotional outbursts, indignation, prevaricating, finger pointing, and loud threats of the disruptive colleague. This tactic will help the leader anticipate her own reactions as well as those of the physician with whom she meets.

As a general rule, it is advisable to have a third party present when talking to a disruptive physician about offending behavior. This may not be necessary for minor first infractions, but is certainly wise when addressing serious patterns of abusive behavior. It is not uncommon for such a practitioner to later distort the encounter—suggesting that he was not informed of the consequences of further conduct violations, was lied to or threatened, or was otherwise dealt with unfairly. Having a witness to the interaction will help to undermine the credibility of such assertions. These discussions should take place somewhere private so that confidentiality is maintained and the physician does not feel forced into a defensive posture. The offices of the medical staff president, the hospital CEO, or the VPMA are good locations for privacy and to impart the gravity of the conversation. Avoid talking to a disruptive doctor in the hospital hallways, doctors' lounge, dining room, locker rooms, or parking lots.

The Conversation

Whoever is designated to speak with a problematic physician, the conversation should begin with an explanation of the authority that person holds to address the behavioral violation. This helps clear up any misconceptions that might occur because of past or current friendships, enmities, referral relationships, conflicts of interest, or other history between the parties to the conversation. It is important to establish that the disruptive physician is not just being confronted by an interfering interloper. For example, the physician leader might say, "I am speaking to you today as the hospital's vice president of medical affairs" or, "The president of the medical staff has asked that I speak with you about your behavior yesterday in the ICU…"

When initially speaking with a colleague whose conduct has been inappropriate, the intent should be to draw the doctor's attention to the instance of problematic behavior. Anyone is entitled to a "bad day," but when others are affected it is necessary and reasonable to speak with the doctor about it. In such a discussion it is important to listen to the doctor's concerns, offer support if appropriate, and acknowledge the value the doctor brings to the institution and patients. Because the goal is to provide effective feedback, the leader's comments

20 Weber, 2004; pp. 10–11.

21 A. H. Rosenstein and M. O'Daniel, "Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians," *American Journal of Nursing*, Vol. 105, No. 1 (2005); pp. 54–64.

22 "Most recent Sentinel Event Alert highlights disruptive behavior," *Briefings on The Joint Commission*, Vol. 19, No. 9, September 2008, HC Pro, Inc.; p. 2.

should stay focused on the disruptive behavior (which can be changed) and not on personality structure (which cannot).

Frequently, when investigating misconduct, a physician leader will find her disruptive colleague will attempt to deflect blame to hospital personnel or other practitioners. Such physicians are also quick to characterize themselves as champions of patient well being and safe medical care. Anyone criticizing them must, therefore, be advocating poor quality medical care and is not entitled to credibility. *The physician leader must not be distracted by these subterfuges.* She must keep the discussion focused on the specific behavior that violated the medical staff code of conduct. One tactic to accomplish this is to avoid arguing whether another staff member did something wrong or whether quality was in fact compromised. The leader should acknowledge these possibilities and indicate a willingness to discuss them *at another time*. Then, the conversation should be brought back to focus on the specific unprofessional behavior of concern.

An important step in working with colleagues on performance issues of any kind is to provide positive reinforcement whenever possible.

An important step in working with colleagues on performance issues of any kind is to provide positive reinforcement whenever possible. This simple collegial intervention is often overlooked. When a physician responds positively to feedback on inappropriate conduct, it should be acknowledged. For example, a leader might actively seek the physician to let him know the following: "Bill, I'm glad I ran into you. I just want you to know that it has been eight weeks since we had our last discussion and I have not had a single complaint from nurses or staff. I really appreciate the effort you're making!"

Every significant encounter with a disruptive physician should be documented in writing, and a copy placed in the practitioner's confidential performance file. A good practice for such documentation is to write a letter to the offending physician and recount the main points of the discussion that occurred. In particular, such a letter should note the behavior described as problematic, any requirements for compliance laid out for the practitioner, and any consequences for repeat violations or non-compliance with the aforementioned requirements. One copy goes to the disruptive practitioner; another copy becomes documentation in his performance file. The letter should be marked as 'peer review protected' so that it is shielded from legal discovery to the extent provided under the law. A sample of such a letter can be found in the Appendix. Any responses from the practitioner should also be kept in that individual's peer review or performance file.

Good Practices When Confronting Disruptive Physicians

- Consider rehearsing the interaction with a friend or mentor before actually meeting with a disruptive physician.
- Reference your authority to address the issue with the offending practitioner (e.g., "I am speaking to you today in my capacity as president of the medical staff").
- Speak in private (i.e., avoid conversations in the hallway, doctors' lounge, or other public spaces).
- Consider having a third party present who can later corroborate the details of the conversation (this is also helpful if the discussion is with someone physically intimidating).
- Keep the focus on discussion of the disruptive behavior—not judgments about the practitioner's intentions, worth, value, goals, etc.
- Don't allow the disruptive practitioner to change the subject—agree to talk at another time about his or her concerns regarding other staff members or about quality issues.
- Reference the medical staff code of conduct and any prior agreement by the practitioner to comply with it (e.g., by signing it along with a membership application).
- Reference any past violations if they have occurred and identify any patterns of misconduct that are in evidence.
- Clearly state the consequences of this or future violations.
- Do *not* agree to talk with the disruptive practitioner's lawyer.
- Ignore threats of legal action but let hospital counsel know when they have been made.
- Immediately document the interaction and confirm any statements made in a follow-up letter to the disruptive practitioner.

Assessing Disruptive Physician Health

Society makes extensive investments in the training of physicians, and doctors represent valuable resources for the communities in which they practice. Everyone benefits if a good doctor can be helped from going down a path that is destructive to himself as well as others. To achieve this, physician leaders should look carefully for remediable causes that may be triggering inappropriate behavior. Perhaps the practitioner has come under new and excessive stresses recently—for example, work overload because of the loss of a partner; the turmoil of a divorce in progress; the pain and angst of a prolonged malpractice defense. While such stresses cannot excuse conduct violations, physician leaders may be able to extend help to a suffering colleague. In the examples above, such assistance could take the form of help recruiting a new partner, referral for counseling, or participation in a malpractice support group.

It is also important to evaluate the possibility of serious underlying illness. Doctors suffer mental health problems with the same frequency as individuals in the general population. Major depression or bipolar disorder may present as unprofessional behavior. Adequate treatment might successfully eliminate episodes of problematic behavior in the work setting. There are at least four types of behavioral sentinel events that might lead physician leaders to seek professional evaluation of a colleague:

- Truly strange or erratic behavior
- Persistent poor anger control or abusive behavior
- Transgression of proper professional boundaries
- A disproportionate number of lawsuits or serious complaints

As the overall physician population ages (40 percent of currently practicing physicians are older than 50), significant physical illness becomes more prevalent. Disruptive behavior can be a manifestation of neurologic disorders or a reaction to the stress of a serious chronic ailment. Inappropriate conduct may be a cover for mild dementia in an internist, a reaction to a new onset tremor in a surgeon, or chronic fatigue in a hospitalist. Physicians are likewise subject to alcohol and drug abuse. These impairments are notorious for presenting for the first time as inappropriate behavior. However, it is estimated that substance abuse accounts for less than 10 percent of physician behavior problems.[23]

Follow-up with a practitioner should occur in the immediate wake of an incident—not weeks later.

Fortunately, there are interventions that can often help when underlying illness is a factor. But first it is necessary to make a diagnosis, and it is often prudent to insist that a disruptive physician undergo evaluation for such underlying problems. Medical staff bylaws should make it mandatory that staff members agree to appropriate examinations when requested by medical staff leaders or committees. A wellness or physician health committee often has expertise in making these arrangements. A list of evaluation and intervention resources can be found in the sidebar below.

Many medical schools have programs that can be accessed for the evaluation of professionals—particularly if there are minor or major psychiatric concerns. Anger management programs can be found readily in all parts of the country. State medical societies and medical boards often maintain lists of resources useful to assess and work with troubled physicians. Many state medical societies sponsor excellent "physician impairment" programs, and a list of such programs can be found on the Web site of Federations of State Physician Health Programs (www.fsphp.org).

Dr. Spence Meighan, a long time physician executive and educator, said, "dealing with impaired colleagues is an act of compassion; dealing with disruptive physicians should be an act of law." When health problems underlie outbursts of inappropriate behavior, we must strive to identify the etiology and assist in recovery. But this will not be the cause for most conduct violations and when it is not, then the most important remedy is strict enforcement of the rules. Indeed, many physician leaders are quick to refer a disruptive practitioner to an impaired physician program because it is a less painful measure than taking necessary disciplinary action.

A Sampling of Assessment, Evaluation, and Remediation Programs

Inner Solutions for Success
P.O. Box 2100204
Chula Vista, CA 91921
General Information: (619) 370-9679
Email: ebeckerlcsw@yahoo.com
Web site: www.innersolutionsfor success.com

Center for Personalized Education for Physicians
7351 Lowry Blvd., Suite 100
Denver, CO 80230
General Information: (303) 577-3232
Web site: www.CPEPDoc.org

UC San Diego, PACE Program
(Physician Assessment & Clinical Education Program)
1899 McKee Street, Ste 126
San Diego, CA 92110
General Information: (619) 543-6770
Email: ucpace@ucsd.edu
Web site: www.paceprogram.ucsd.edu

Acumen Assessments
901 Kentucky, Suite 301
Lawrence, Kansas 66044
General Information: (785) 856-8218
Email: acumeinfo@acumenassessments.com
Web site: www.acumenassessments.com

Progressive Interventions and Disciplinary Suspensions

When responding to professional misconduct, physician leaders should follow a policy of intervening early and often. Follow-up with a practitioner should occur in the immediate wake of an incident—not weeks later. Minor infractions should not be ignored—doing so may be interpreted as permission to misbehave. Successive interventions should be progressive, but

23 Weber, 2004; p. 7.

determined by the risks posed to patients and staff. A series of progressive steps is outlined below. However, it should be clear that early steps can be skipped when a practitioner is throwing scalpels or engaging in fist fights with colleagues.

A list of progressively more severe interventions with a disruptive practitioner might include the following:

- Remind the practitioner of the applicable code of conduct (informal meeting).
- A written reminder of requirement to comply with the code of conduct at all times.
- A formal meeting to discuss a significant incident or pattern of unprofessional behavior (this can be with a medical staff leader, board representative, influential colleague, VPMA, or other authorized individual).
- A formal letter of concern regarding ongoing misconduct and a description of consequences for future infractions.
- A mandatory appearance before the medical executive committee to explain non-compliance with the code of conduct.
- A formal evaluation of the practitioner by an outside program.
- A letter of reprimand in the credentialing file.
- Imposition of a disciplinary suspension (see description below).
- Imposition of a conditional reappointment.
- Requirement for participation in an appropriate behavioral management program.
- Loss of privileges or membership.

Many medical staffs have found it useful to add the use of a "disciplinary suspension" to their armamentarium of corrective action measures. This tool is most helpful with disruptive physicians who think they will never ultimately be terminated for their ongoing non-compliance with medical staff rules. This thinking is often reinforced by a history in many hospitals of failing to take definitive action against unprofessional behavior. It is even more firmly held if the violator is a high-revenue generator for the institution.

The disciplinary suspension can serve as a wake-up call to convince the disruptive physician that the institution is serious about enforcing proper conduct. This suspension occurs only after previous attempts to address the misbehavior and the doctor has been given written warning that a suspension is next in the progression of disciplinary steps. The suspension is applied for no more than 14 days, during which time the practitioner may not admit any new inpatients or perform consultations. Because this suspension is of short duration, it need not trigger a fair hearing unless medical staff bylaws require otherwise. It is not reportable to the National Practitioner Data Bank because the suspension does not last for more than 30 days. Indeed, the hope is that it will prevent the need for both of these actions by convincing the offending doctor that a full suspension will be forthcoming if there are future code-of-conduct violations.

Medical staff leaders should not shy away from recommending termination of membership of a persistently disruptive physician when lesser interventions have not succeeded.

In the end, it may be necessary to terminate the membership of a persistently disruptive physician. Medical staff leaders should not shy away from such a recommendation when lesser interventions have not succeeded. A culture of safety and excellence will never prevail at an institution that allows doctors to flaunt inappropriate professional behavior.

In recommending termination to the hospital board, medical staff leaders should provide good documentation of the continuing violations and the efforts to address them. Hospital legal counsel should never be blindsided with the recommendation, but rather should be consulted early when termination is being considered.

If bylaws allow it, consideration should be given to using a hearing officer instead of a panel of peers to carry out the fair hearing. Since specialized clinical matters aren't the subject matter of the hearing, the clinical expertise of peers is not required. Whether or not a panel is used, the hearing should be guided by an experienced presiding official to establish the ground rules and oversee the proceedings. Not surprisingly, disruptive practitioners often act out in hearings and make the proceedings difficult. What's more, disruptive doctors often hire disruptive lawyers to represent them!

Legal Challenges to the Management of Unprofessional Conduct

There is no question that the medical staff corrective action process can be misused, and disruptive physicians are quick to level this accusation. However, the data clearly show that although there are tens of thousands of physicians engaging in problematic behavior across the nation, there are only isolated documented instances of corrective action abuse. Nevertheless, doctors who have been terminated from medical staffs or have lost privileges because of unprofessional conduct frequently try to overturn these decisions through lawsuits. In general, courts have found the disruptive behavior of a provider was actionable when the hospital investigation yielded two important elements:

1) Objective, clear, and convincing documentation of the disruptive behavior
2) Evidence demonstrating that such behavior adversely affects or could affect patient care

Most disruptive physicians lose their court cases unless a hospital has clearly mishandled basic due process or clearly violated its own policies or medical staff bylaws. Good documentation of the steps the hospital took is essential to counter the distortions often promulgated by the plaintiff physician.

Disruptive physicians commonly claim to be quality advocates who are being punished for championing patient safety. Judges rarely have any trouble seeing through these charades. However, it is always prudent to carry out an investigation of quality concerns when raised by any practitioner—including those with inappropriate behavior. While state and federal whistleblower statutes might apply to physicians who are retaliated against for exposing quality concerns, they are not meant to shield inappropriate conduct. Courts have little difficulty recognizing when proper reporting channels have not been used and it takes no clinical expertise to recognize most professional misbehavior. (See the case study on Gordon v. Lewistown, page 18.)

The disruptive physician may attempt to get an injunction or restraining order to block implementation of a suspension or termination. Hospitals and medical staffs should move to block these efforts. Courts are usually reluctant to intercede in professional review actions. Judges will typically avoid determining if the behavior of the physician negatively affects patient care and defer such decisions to the hospital medical staff.

It is important to strictly follow any conflict of interest requirements found in the due process provisions of the medical staff bylaws, and it is generally prudent to recuse competitors from the vote at the medical executive committee meeting where a recommendation of suspension or termination takes place.

It is also common for judges to insist that a physician exhaust all the internal appeals offered by the hospital before considering an action by the court. When a hospital has complied with its own medical staff bylaws and provided the due process steps required by the Health Care Quality Improvement Act (HCQIA), it can usually win dismissal of the case in a motion for summary judgment. This is because HCQIA has immunity provisions for healthcare organizations undertaking professional review actions properly.

Sometimes disruptive physicians claim they are being discriminated against by the hospital on the basis of race, gender, or some other illegal criterion. These cases are typically heard in federal court where there are no protections of peer review material from discovery. Once again, the courts usually can detect when these allegations are groundless, and the plaintiff physician is required to provide more evidence than just allegations before he will get a day in court.

Another tactic undertaken by disruptive physicians is to claim they have been the victims of a conspiracy among their competitors. It is important to strictly follow any conflict-of-interest requirements found in the due process provisions of the medical staff bylaws, and it is generally prudent to recuse competitors from the vote at the medical executive committee meeting that recommends suspension/termination. The bylaws should prohibit direct competitors from serving on any fair hearing committee that is formed to assess the corrective action taken against a physician.

Sometimes disruptive doctors tell the courts they have been singled out unfairly for their behavior while other offenders have been ignored. They claim improper, disparate treatment and ask the courts for access to all peer review records so they can make their case. Judges usually recognize these as fishing expeditions by plaintiffs' attorneys and most of the time will not allow the files of other doctors to be discovered.

Common Mistakes in Dealing with Disruptive Physicians

- Making excuses for the disruptive behavior
- "Circling the wagons" to provide a show of collegiality
- Being intimidated by threats of legal action
- Failing to investigate "quality concerns" when alleged by disruptive practitioners
- Allowing a disruptive doctor's allegations of wrong-doing by others distract from addressing that doctor's own unprofessional conduct
- Manufacturing evidence of clinical deficiency to support allegations of unprofessional behavior
- Failing to act promptly on every incident of disruptive conduct
- Not clearly communicating behavioral expectations (through a code of conduct, physician compact, or other articulation of performance expectations)
- Failing to strictly enforce a code of conduct
- Responding to physician disruptive conduct differently from other disruptive employees or practitioners

Additional Legal Challenges

Early in this white paper it was observed that lawsuits from aggrieved hospital staff members have been a major motivator for addressing the disruptive conduct of physicians. Over the years, many of these suits have been brought by nurses alleging sexual harassment. More recently, lawsuits by some hospital personnel have alleged hospital failure to prevent a "hostile workplace environment." The courts have noted that unprofessional conduct does not have to be aimed directly at a worker for that individual to be negatively affected. Harassing or intimidating a single nurse in a critical care unit may negatively, and illegally, affect all who work there. When hospitals repeatedly fail to address unprofessional behavior, these lawsuits result in large judgments. This white paper does not include a discussion of the many appropriate steps hospitals should take to reduce or eliminate the potential for these claims, but the literature is replete with sound advice.

There is another plaintiff that brings cases as a result of a hospital's management of unprofessional conduct—the injured patient. His lawyer will allege that if the institution had not ignored the disruptive conduct of a medical staff member, then the patient would not have suffered the negative outcome that is the basis of the lawsuit.

In the end, medical staffs and hospital boards have to do what is right, even though litigation may result. Between the Scylla and Charybdis of disruptive physicians and litigation-prone patients, hospitals must address unprofessional behavior fairly and definitively. Well-trained medical staff leaders and close consultation with hospital counsel at all steps of intervention with disruptive physicians can prevent later disasters in the courtroom.

Case Study: Gordon v. Lewistown Hospital

Dr. Gordon's staff privileges were first suspended in 1992 because of inappropriate conduct. He was publically critical of the skills of the only other ophthalmologist on staff in many improper ways. Dr. Gordon was suspended again several years later for, among other actions, making harassing phone calls to patients, criticizing another physician on the medical staff and soliciting that doctor's patients in the hospital, screaming obscenities at operating room nurses, and telling his competitor's hospitalized patients that they should not go forward with planned surgery. Following this suspension, Dr. Gordon was reappointed to the medical staff, subject to several "conditions of reappointment." By these conditions, Dr. Gordon agreed to refrain from calling the patients of other doctors, use proper administrative channels for voicing complaints, and otherwise comply with the rules and regulations of the hospital. Soon thereafter, Dr. Gordon committed multiple violations of the conditions of reappointment and his staff appointment was revoked.

Dr. Gordon filed an antitrust action against Lewistown Hospital. He claimed that the hospital's termination of his privileges was because of the competition it faced from his freestanding surgery center. He alleged that the hospital's restriction of his ability to denigrate his competition to patients awaiting surgery in the hospital was anti-competitive. He described his actions as in furtherance of quality medical care. After a three-week trial, Judge Sylvia Rambo of the U.S. District Court handed down a 102-page decision finding that Dr. Gordon's testimony was not credible and that he had brought the litigation to fulfill a "desire to ruin the hospital by dragging it through protracted and expensive litigation." The opinion went on to state that Dr. Gordon had:

> **"…demonstrated a willingness to lie about his disciplinary history with the Hospital, a desire to cause the Hospital to fail financially, and a need to disrupt the Hospital's operation when the opportunity presents itself."**

Judge Rambo found that it was the plaintiff in this case who engaged in anti-competitive behavior, and not the hospital. With regard to the conditions of reappointment imposed by the hospital, her opinion went on to say,

> **"Given Dr. Gordon's extensive history of calling and otherwise contacting [his competitor's] patients to comment on his medical competency, Conditions [of reappointment] were not only reasonable, but *required*. Dr. Gordon's reckless remarks exposed the Hospital to potential medical malpractice lawsuits. Moreover, the Hospital's 'public service' function also required that the Hospital, to a limited extent, shield patients from the oftentimes harsh realities of capitalistic competition. Hospitals are not only in the business of making money; they also exist to help patients get better. Thus, the Hospital has a vested interest in making sure that patient care takes precedence over physician profit."**

On appeal, the Third Circuit upheld the district court's ruling. The appellate court flatly rejected Dr. Gordon's arguments that immunity was not available to the hospital because his conduct did not adversely affect patient care. The court found that the physician's "harassment and intimidation of elderly patients by calling them to disparage [their physician's] skills" could adversely affect the health and welfare of patients, and thus the hospital's action qualified as a professional review action. The court also upheld the dismissal of the remaining antitrust claims brought against the hospital.

Although Dr. Gordon is a "textbook" disruptive physician whose allegations were clearly bogus in the eyes of the courts, he did manage to tie Lewistown Hospital up in litigation for nearly a decade. Such cases are prime examples of the old maxim, "no good deed goes unpunished."

Conclusion

Despite the ongoing stress of a career in healthcare, there is reason to hope that the prevalence of unprofessional behavior will diminish in the years ahead. The growing willingness of hospitals to adopt a "zero tolerance" stance toward disruptive conduct will facilitate this trend. The increased efforts to train and prepare physician leaders in the management of this problem will also have a large impact. The development in more and more healthcare organizations of true cultures of excellence will play a part as well.

In these turbulent times, there is a great deal of public focus on the performance of healthcare practitioners and institutions. The unprofessional conduct of some demeans the integrity and reputation of all. For the near term, effectively addressing disruptive conduct will remain one of the most challenging and pressing demands on physician leaders. This must continue to be a professional and collegial imperative from which many parties will benefit: patients, nurses, and hospitals. Not least among the beneficiaries will be the community of physicians. Dealing with colleagues who engage in unprofessional behavior is an example of an old Hindu proverb: *Help your brother's boat across and your own will reach the shore.*

Appendix: Sample Letter Documenting Collegial Interaction

June 5, 2009

Maurice Murphy, M.D.
200 Medical Plaza, Suite 210
Emerald City, Oz 21111

Dear Dr. Murphy,

This letter recaps our conversation yesterday in my office. At that time I shared with you several complaints that have been lodged by nurses on the pediatric floor of our hospital. One involved your use of obscene language in berating a nurse while in the presence of at least one patient and her family. A second event we discussed was your response to a nurse who you believe paged you unnecessarily. Again, an obscenity and demeaning language were used. My investigation of both matters has substantiated that a violation of our code of conduct took place.

This is not the first time an officer of this medical staff has spoken to you about this kind of unprofessional behavior. Yesterday I reviewed with you the expectations laid out in our medical staff code of conduct and I have attached a copy for your files. I am pleased that you offered to make an apology to the nurses in pediatrics. I encourage you to do this promptly to dispel any lingering tensions between you and the nursing staff.

As we discussed, any further conduct violations that take place will result in the following actions:

1) A requirement to appear before the MEC to explain your inability to comply with the professional norms and behavioral expectations established for this hospital.
2) A letter of reprimand will be placed in your performance file and its presence may be made known to third parties that seek formal references from our medical staff office.

I have the utmost faith that you will see that there are no further incidents of this nature. If you believe you need help in this regard, I am happy to work with you to make appropriate arrangements. However, I want to be quite clear that unprofessional behavior will not be tolerated going forward.

Sincerely,

James Brown, M.D.
Chief of Staff
All Saints Hospital

References

Becker, E. and Norcross, W. "Dealing with Disruptive Physician Behavior." FORUM, Vol. 24, No. 3, October 2006. Cambridge, MA: CRICO/RMF. Available at www.rmf.harvard.edu/forum.

Hickson, G. B. "A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors." *Academic Medicine*, November 2007, 82(11). Philadelphia, PA: Lippincott Williams & Wilkins.

Kahn, M. W. "Etiquette-based medicine." *New England Journal of Medicine*, 358:19, May 8, 2008. Waltham, MA: Massachusetts Medical Society.

Keogh, T. and Martin, W. "Managing unmanageable physicians." *Physician Executive*, September/October 2004, 30(5). Tampa, FL: American College of Physician Executives.

Kohatsu, N., Gould, D., Ross, L., and Fox, P. "Characteristics Associated with Physician Discipline." *Archives of Internal Medicine*, Vol. 164, March 22, 2004. Chicago, IL: American Medical Association.

Lazoritz, S. "Coaching for Insight: A tool for dealing with disruptive physician behavior." *Physician Executive*, January/February 2008. Tampa, FL: American College of Physician Executives.

Leape, L. L. and Fromson, J. A. "Problem Doctors: Is There a System-Level Solution?" *Annals of Internal Medicine*, Vol 144, 2006. Philadelphia, PA: American College of Physicians.

Marshall, P. and Robson, R. "Preventing and managing conflict: Vital pieces in the patient safety puzzle." *Healthcare Quarterly*, October 2005. Toronto, ON: Longwoods Publishing.

Papadakis, M., et al. "Disciplinary Action by Medical Boards and Prior Behavior in Medical School." *New England Journal of Medicine*, 353:25, December 22, 2005. Waltham, MA: Massachusetts Medical Society.

Papadakis, M., et al. "Performance during Internal Medicine Residency Training and Frequent Disciplinary Action by State Licensing Boards." *Annals of Internal Medicine*, Vol. 148, No. 11, June 3, 2008. Philadelphia, PA: American College of Physicians.

Pfifferling, J. H. "Managing the unmanageable: the disruptive physician." *Family Practice Management*, Vol. 4, No. 10, 1997. Leawood, KS: American Academy of Family Physicians.

Porto, G. and Lauve, R. "Disruptive clinical behavior: A persistent threat to patient safety." *Patient Safety and Quality Healthcare*, July/August 2006. Marietta, GA: Lionheart Publishing, Inc. Available at www.psqh.com/julaug06/disruptive.html.

Ransom, S. B. and Neff, K. E., et al. "Enhancing physician performance." *Physician Executive*, September/October 2004, 30(5). Tampa, FL: American College of Physician Executives.

Reed, D., West, C., Mueller, P., Ficalora, R., Engstler, G., and Beckman, T. "Behaviors of Highly Professional Resident Physicians." *Journal of the American Medical Association*, Vol. 300, No. 11, September 17, 2008. Chicago, IL: American Medical Association.

Rosenstein, A. H. "Nurse–Physician Relationships: Impact on Nurse Satisfaction and Retention." *American Journal of Nursing*, June 2002, Vol. 102, No. 6. Philadelphia, PA: Lippincott Williams & Wilkins.

Rosenstein, A. H. and O'Daniel, M. "Disruptive behavior and clinical outcomes: Perceptions of nurses and physicians." *American Journal of Nursing*, Vol. 105, No. 1, 2005. Philadelphia, PA: Lippincott Williams & Wilkins.

Rosenstein, A. H., et al. "Disruptive physician behavior contributes to nursing shortage: Study links bad behavior by doctors to nurses leaving the profession." Physician Executive, November/December 2002, 28(6). Tampa, FL: American College of Physician Executives.

Sieber, W. and Becker, E. "Knowledge of Professional Boundaries: Initial Validation of a Measure." *Journal of Medical Licensure and Discipline*, Vol. 92, No. 2, 2006. Dallas, TX: Federation of State Medical Boards of the United States, Inc.

Summer, G., Ford, C., and Lightfoot, W. "The Disruptive Physician I: The Alabama Physicians Recovery Network." *Federation Bulletin*, 84(4), 1997.

Weber, David O. "Poll Results: Doctors' Disruptive Behavior Disturbs Physician Leaders." *Physician Executive*, September/October 2004, 30(5). Tampa, FL: American College of Physician Executives.

Williams, M., et al. "A Systems Approach to Disruptive Behavior in Physicians: A Case Study." *Journal of Medical Licensure and Discipline*, Vol. 90, No. 4, 2004. Dallas, TX: Federation of State Medical Boards of the United States, Inc.


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