



National Peer Review Corporation

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Hospital Peer Review Guide III: Handling the Disruptive Physician

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Introduction

Hospital and medical staff decision-makers often hesitate to initiate a review of a disruptive physician. In addition to internal political considerations, this reluctance arises, in many instances, because the evidentiary basis for the review may appear too subjective to support a peer review action. Despite these concerns, a hospital cannot ignore its legal obligation to take action to protect the safety of patients, other physicians, nurses and staff from the disruptive conduct of a physician.

But what constitutes “disruptive conduct” and what kind of evidence is needed to show an “adverse affect” on patient care?

The biggest obstacle for most hospitals is determining if a physician’s behavior constitutes disruptive conduct. Most physicians and administrators recognize abusive language, throwing things, or physical intimidation as actionable disruptive behavior. The real dilemma is when the physician’s behavior is more subtle, such as sarcasm, emotional isolation, or verbal intimidation. In these circumstances, many physicians and administrators are unable or unwilling to distinguish when a threshold has been reached and peer review action is necessary.

Contributing to this inherent reluctance is the lack of clear, documented direction in the medical staff bylaws or other hospital manuals for proceeding with a peer review action based on a physician’s professional conduct. Although most medical staff bylaws contain provisions for the education or discipline of disruptive physicians, these provisions often fail to provide the guidance needed to initiate and investigate a peer review action based on disruptive conduct. By its very nature, the professional review action for a disruptive physician is complex, involves high-level hospital and medical staff politics and poses a serious threat to the hospital. Therefore, the probability of mishandling the process is substantial and can have severe effects.

Additional issues arise when the physician is reviewed due to disruptive conduct and concerns regarding their clinical competence. Of primary concern is maintaining the credibility of the peer review process while conducting a thorough investigation of both issues.

The following topics will assist hospital decision-makers in recognizing disruptive conduct, making the connection between disruptive conduct and its effects on patient care, avoiding hospital actions that can exacerbate the effects of the disruptive conduct for both the hospital and the physician, and initiating the appropriate procedures to comply with legal obligations.



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1. The Disruptive Physician - Defined

A disruptive physician has been defined as follows:

The disruptive practitioner is by definition, contentious, threatening, unreachable, insulting and frequently litigious. He will not, or cannot, play by the rules, nor is he able to relate to or work well with others. . . . This physician often falls within the classification of the impaired or sick physician, in that the underlying reason for the physician's abusive conduct may be a mental or emotional problem. However, that is not always the case. Sometimes the person is simply a disruptive or abrasive human being.

The manifestation of disruptive behavior sometimes takes bizarre forms. The disruptive physician is often clinically competent. Indeed, he will believe himself to be more competent than others on the medical staff. It is not uncommon to find that a disruptive practitioner is, in fact, highly intelligent, clinically superior, even medically outstanding. However, the reason for his disruptiveness, his inability to get along with others, sometimes affects his clinical judgment. He is totally convinced that he is right. Those who would question him or seek to have him behave differently, whether they are colleagues or not, are seen to be motivated by ignorance, stupidity, jealousy or a desire to destroy him as an economic competitor. They are also believed to be weak and vulnerable. In fact the objects of his unacceptable behavior are most frequently those who, by virtue of their positions, are weak and vulnerable. He may not openly take on the strong and prestigious, but rather seek to undermine and intimate those who can neither avoid him nor fight back. For these reasons, and regardless of what may cause him to act as he does, he is a formidable person.

. . . Only when personal idiosyncrasies, as expressed in words or deeds, begin to affect the ability of others to get their jobs done, or impinge on their right to go about their own business free of burdensome harassment, or when such idiosyncrasies begin to interfere with the practitioner's ability to perform well professionally, is action by the hospital indicated.¹



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2. What Constitutes Actionable Disruptive Conduct

Case law has determined that the disruptive conduct of a physician was actionable when the hospital investigation yielded two (2) essential elements:

1. Objective, clear and convincing documentation of the disruptive conduct; and
2. Evidence demonstrating that such conduct adversely affects patient care.

2.1 Disruptive Conduct

In each of the following cases, the hospital and medical staff decision makers acted to prevent further disruptive conduct by a physician (usually by the termination of medical staff membership) and the courts upheld the action concluding that the behavior of the physician constituted disruptive conduct and adversely affected patient care:

In Yarnell,² the physician had “been threatening and abusive of medical staff personnel and...generally disruptive of hospital procedures.”

In Ladenheim,³ the physician:

“told a physical therapist that she had body odor and repeated the conversation to two other hospital employees.”

“sent a note indicating the office staff was stupid.”

“refused to complete a medical planning form titled ‘Discharge Planning’ on a nursing home patient, writing ‘you dreamer’ across the space provided for his input.”

“made disparaging remarks to or refused to work with a particular nurse, and in one instance told her that an emergency room patient could go to another hospital ‘or go to hell’ as far as he was concerned, because the patient was receiving medical assistance from welfare.”

“refused to bring his criticisms of the nursing staff to the director of nursing, circumventing her entirely in favor of complaining to the hospital administrator.”

“indicated to another staff member that it was useless to request the nursing director’s assistance, because she would not take any action.”

In Kiracofe,⁴ the physicians conduct was described as “continuing to refuse to explain orders to nurses, abusive behavior towards nurses who questioned his orders, entering inappropriate and defamatory statements in medical records, failure to complete medical records in a timely fashion, and giving orders which were inappropriate and potentially harmful.”



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In Bryan,⁵ the physician had been cited for misconduct in excess of fifty times. For example, he:

told other physicians that he “didn’t give a damn about incompetent people’s excuses” then “launched into a tirade of insults in loud and angry tones in front of a still conscious patient.”

“slapped the hands of a technologist.”

“struck the hands of nurse.”

In Manasara,⁶ the physician:

“referred to nurses as ‘bitches’, and called them ‘stupid’ and ‘lazy’, threatened the loss of their jobs, yelled, and used obscenities.”

gave “verbal orders and later denied doing so.”

showed an “unwillingness to listen to certain nurses when they attempted to report changes in infant patients’ conditions.”

“made offensive racial remarks.”

In Landefeld,⁷ the physician had been caught “rifling through the hospital mailboxes of other physicians, stealing or disposing of their mail.”

In Cipriotti,⁸ the physician “entered inappropriate and disrespectful comments on a patient’s chart; on one occasion he improperly circumvented hospital’s admitting procedure in order to admit a patient.”

In Morgan,⁹ the physician committed sexual harassment.

In Nieto (v. Kapoor),¹⁰ the physician exhibited numerous acts of disruptive conduct and made racially and sexually harassing statements to nurses, patients and other staff, including:

On at least thirteen occasions, the physician specifically referred to Mexicans as “stupid,” “lazy,” or both.

In the presence of a Mexican staff member, the physician told a white patient that her daughter had “degraded herself and her family” by marrying a Latino man.

The physician provided different levels of treatment to hospital patients based on their race and at times refused to treat Latino or African-American patients or would give them less attention and care than white patients.

The physician regularly pushed and pulled employees down the hall and grabbed things from their hands. He pointed fingers in their faces as he yelled at them. He also threw such things as pencils, medical charts, and records at employees, as well as throwing a hardback copy of the Physician’s Desk Reference at a hospital employee.



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The physician repeatedly described women as being “whiny” and “overly sensitive” or “stupid.” He made numerous comments characterizing women as greedy or weak.

The physician assigned menial tasks only to female employees, requested assistance from male employees with significantly less experience and showed preference to male employees during training, including yelling or ignoring female employees who asked questions or attempted to point out problems in patient care.

The physician treated female patient differently than male patients, offering them less privacy, time and respect. Specifically, he engaged in behavior intended to degrade female breast cancer patients.

In Gordon,¹¹ the physician “told a nurse that ‘she should get off her ass and that she was a wrench in the works’, she was obstructing patient care.”

In Brader,¹² the physician was “rude, offensive and insubordinate” to a medical staff officer; changed the locks on his office door and did not provide keys to administration.

In Robbins,¹³ the physician interrupted a training class, was not available while on call for the emergency room and refused to care for another doctor’s patient.

In Catipay,¹⁴ the physician exhibited unprofessional conduct by posting sexually explicit articles on a hospital bulletin board, appeared to threaten a nurse with whom he had had an argument and sending sexually explicit postcards to hospital staff from a vacation.

In Curtsinger,¹⁵ “there were reports that, in October 2002, Dr. Curtsinger disrupted the ER by ‘ranting and raving’ for at least one hour regarding the process by which a patient came into the ER. Dr. Curtsinger’s disruptive behavior and inappropriate commentary affected the ER nursing staff and at least a few physicians...”

In Blau,¹⁶ “Blau’s conduct reduced several of the nurses to tears. Nurse Jean Baker testified that Blau’s behavior caused her heart palpitations, sleeplessness, and nightmares. In Fall 1999 she was admitted to the Hospital due to chest pains and filed a workers’ compensation claim. In March 2000, nurse Christine Benton was hospitalized for a rapid heart rate resulting from stress that she attributed to Blau. On her doctor’s advice, she submitted a declaration rather than testifying at the hearing.”



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In Johnson,¹⁷ the physician “made rude and inappropriate remarks and conduct towards [sic] staff members, a patient, and a physician, often in a raised voice or in a demeaning, insulting, or offensive tone. Additionally, ... made unreasonable demands on staff members, demonstrated a lack of cooperation, ... failed to follow usual and customary practices with respect to surgical scheduling, equipment requests, orders, and informed consent, demonstrated a cavalier and inappropriate attitude towards [sic] cases, unduly delayed seeing a trauma patient, failed to timely follow-up on patient care requests... Finally, the [MEC] considered [the] history of failing to promptly respond and cooperate in the peer review process...”

In Gekas,¹⁸ “Ten witnesses testified as to difficult and inappropriate encounters with Dr. Gekas, some of which occurred in the presence of hospital patients and their families. Much of the conduct testified to can easily be characterized as ‘disruptive, unprofessional, indecent or abusive,’ and inconsistent with the cooperation between staff members required for a hospital’s proper functioning.”

In Arunasalam,¹⁹ “the MEC summarily suspended Arunasalam’s privileges ‘based on a pattern of capricious, hostile, and disruptive conduct . . . that included dishonesty, defiance of MEC directives, disregard for patients’ welfare, and substandard medical practice.’ Arunasalam, in direct contravention of two prior directives, attempted [a procedure]. While performing an angioplasty, with the patient on the procedure table, Arunasalam left the room, telephoned the St. Mary acting chief of staff, and demanded permission to [perform the procedure]. When Arunasalam was denied permission, he “terminated the procedure prematurely.” The patient experienced serious health problems... After being denied permission, Arunasalam twice stated to the acting chief of staff, ‘I hope the patient dies.’”

In Pourzia,²⁰ the court ruled that there “was substantial evidence to support the findings in each charge sustained, conflicts in evidence notwithstanding. . . . Although Dr. Pourzia minimizes each of the subject incidents, collectively they reflect a serious disruption of hospital morale and efficiency.”

In Straznicky,²¹ the court ruled in favor of the hospital regarding a confrontation in an OR and past disruptive conduct stating “Straznicky argues, elsewhere in his opposition, that his conduct on February 2 ‘did not create an on-going imminent harm to patients.’ The argument ignores that past disruptive conduct can be indicative of an underlying characteristic that could manifest in future disruptive conduct. When the nature of the disruptive conduct indicates both that an imminent harm to a patient occurred and that the failure to take immediate action may result in imminent danger to the health of individuals, a reviewing body can reasonably believe that an immediate, summary suspension is warranted. The nature of Straznicky’s conduct was such that the MEC could reasonably believe that a summary suspension was warranted.”



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In Leal,²² “Dr. Leal became so enraged that he broke a telephone, he shattered the glass on a copy machine, he shoved a metal cart into the doors of the operating suite so hard that it damaged one of them, he threw jelly beans down the hallway in the surgical suite, he ‘flung a medical chart to the ground’ when a nurse asked him for written authorization to proceed with surgery, and he ‘verbally abused a nurse manager’ by raising his voice, using profanity, and calling her a liar.” As a result of this tirade the hospital suspended Dr. Leal for sixty (60) days and reported him to the National Practitioner Data Bank. He contested the report to the National Practitioner Data Bank and the Secretary of Health & Human Services, but a lower federal court and the federal appeals court all sided against him.

In Guier,²³ Dr. Guier’s medical staff membership and clinical privileges were terminated. The court stated that “[p]rior to the events leading to this litigation, the operating room staff at St. John’s had refused to work with Dr. Guier on two occasions due to his disruptive behavior... A focused review of Dr. Guier’s performance at the hospital was conducted from December 1, 2005 through May 31, 2006. The summary report from that review stated that ‘[r]epeated instances of behavioral issues with Dr. Guier have created a strain in the working relationships between Dr. Guier and some members of the staff...’ The workplace discord reached a crisis level on October 16, 2006 when the MEC was presented with a “Work Refusal Petition” signed by the entire operating room staff. The Petition stated:

This petition represents repeated documented occurrences in the operating room as well as psychological abuse in a hostile work environment. This petition also represents the concerns of the current operating room staff at St. John’s Medical Center. These concerns are in reference to Dr. Chris Guier and his repeated abuse to the operating room staff. We have exhausted our pleas for change and have finally resorted to this method of resolution. As of this 16th day of October.

2006, the Operating Room staff at St. John’s Medical Center refuses to continue performing any cases with Dr. Chris Guier. The signatures below support this letter, as a much anticipated resolution is needed.”

The court the decision of the district court affirming a decision by St. John’s Medical Center Board of Trustees to revoke Dr. Guier’s medical staff privileges.

In Sternberg,²⁴ the court affirmed the dismissal of Sternberg’s lawsuit challenging a precautionary suspension by the hospital. The court stated, “Sternberg’s ‘imminent danger’ argument presents a more difficult question. As he notes, most interim suspensions are imposed because the doctor is incompetent; exercises poor medical judgment; or is impaired because of substance abuse. The fact patterns in those cases readily provide the basis for a concern that the doctor may cause imminent danger (cite omitted). Here, by contrast, it is undisputed that Sternberg is a competent orthopedist and that he has never actually harmed anyone, despite all of his outbursts. Moreover, the reporter incident, for which he was suspended, was not nearly as disruptive, or potentially dangerous, as



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the July incident (where Sternberg was enraged, and waved a drill in his hand) for which he was not suspended. In sum, Sternberg argues that neither Werner nor the MEC had a reasonable basis to believe that his conduct could be an imminent danger to someone's health. ... The problem with Sternberg's argument is that it does not take into account his long history of disruptive behavior and the circumstances leading up to the suspension. Sternberg has not presented evidence to rebut the written statements and consistent deposition testimony recounting his unprofessional behavior - he yelled at staff members and other doctors, demeaned patients, kicked doors, threw charts, and generally overreacted to problems that arise in any hospital, such as scheduling conflicts and mistakes in providing operating room supplies. By the time he brought the reporter in to observe, Sternberg knew that the MEC was recommending that his staff appointment and hospital privileges be revoked. Werner could not have been clearer in warning Sternberg that any additional incidents of disruptive behavior would result in immediate suspension.

It is against this much larger backdrop that Werner and the MEC evaluated the reporter incident. Sternberg knew that he was not allowed to engage in political activities in the hospital, but he disregarded that prohibition by bringing a reporter into an operating room under false pretenses. These facts, without more, may not provide a reasonable basis to conclude that anyone was at risk of harm during that operation. But it is entirely reasonable to conclude that a doctor (a) with a long history of outbursts and uncontrolled anger; (b) who flouts the hospital's rules in an operating room setting; (c) knowing that he is under a 'zero tolerance' directive; is engaging in self-destructive behavior. Werner and the MEC did not have to wait until that self-destructive behavior resulted in actual harm (cite omitted). Based on his most recent conduct, it was reasonable to believe that Sternberg was uncontrollable and, therefore, presented a threat of harm to patients or staff."

In Jablonsky,²⁵ the court stated, in confirming a judgment against a suspended physician, "[i]n analyzing [physician]'s contention, the court begins by noting that the motivating factor in [hospital]'s suspension/revocation of [physician]'s hospital privileges was the abrasive and disruptive nature of [physician]'s behavior that lead to what [hospital] characterizes as a breakdown in communications between [physician] and the hospital's staff and other physicians. In this regard, the court notes that the idea of professional competence or incompetence is broad. In the context of patient care in the extraordinarily complex setting of a hospital, it is obvious that 'competence' is multi-dimensional. It includes not only medical knowledge and skill, but also a basic knowledge of the workings and needs of the institution and the ability to constructively interact with other healthcare providers in an institutional setting. Further, the court notes that, contrary to [physician]'s contention, there is no requirement that there be an imminent threat to the physician's patient or patients or to any identifiable patient. The court finds that the term 'any patient' as used in section 809.5 incorporates patients in the abstract as well as any identifiable patient. Thus, summary suspension would be warranted where a physician's behavior is sufficiently disruptive as to potentially jeopardize the flow of care to any patient anywhere in the hospital at any time."



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In *Welchlin*,²⁶ the court ruled for the hospital in a case where the physician was warned that “due to the [two previous] incidents and physician’s conduct, an additional complaint could result in suspension of appellant’s hospital privileges...” Thirteen days later, the physician “reacted to a delay in surgery by raising his voice and accusing staff of deliberately delaying him. Appellant grabbed a surgical drape from an individual with such force that it tore in half. Appellant’s behavior caused staff to feel threatened and intimidated.”

2.2 Non-Cooperation as Disruptive Conduct

The medical staff bylaws of most hospitals require, as a condition of medical staff membership, that a physician have a positive working relationship with the medical staff, the nurses and other support staff, and with the hospital administration.

Courts have recognized the right of a hospital and its medical staff to credential, recredential and discipline physicians based upon medical staff bylaws requiring such cooperation.

One court stated:

As a specific type of unprofessional conduct, behavior “disruptive to the operations of the hospital” or, stated another way, an inability to work with other health care personnel at the hospital, is a matter of legitimate concern to a hospital in making medical staffing decisions. Consequently, virtually all of the courts addressing the issue have held, and this Court hereby holds, that a hospital may adopt and enforce a medical staff bylaw providing that the disruptive conduct of a physician, in the sense of his or her inability to work in harmony with other health care personnel at the hospital, is a ground for denying, suspending, restricting, refusing to renew or revoking the staff appointment or clinical privileges of the offending physician, when such inability may have *an adverse impact* upon overall patient care at the hospital (emphasis added) (citations omitted).²⁷



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2.3 The Disruptive Conduct Must Adversely Affect Patient Care

The courts require that the conduct of a physician present a “realistic and specific threat to the quality of medical care” (Silver²⁸) and that there be a “direct link between [the conduct] and [the] potential effect on patient care” (Miller²⁹).

From the perspective of the medical literature, Drs. Leape and Fromson in “Problem Doctors: Is There a System-Level Solution”³⁰ state:

Disruptive, intimidating, or abusive behavior may increase the likelihood of errors by leading nurses, residents, or colleagues to avoid the disruptive physician, to hesitate to ask for help or clarification of orders, and to hesitate to make suggestions about patient care (cites omitted). Such behavior may also deflect the physician’s attention from the patient, thereby impairing clinical judgment and performance. When patients witness disruptive behavior, it undermines their confidence in the physician and the institution, as well as their willingness to partner in their own care (cite omitted). Consequently, disruptive behavior by physicians not only threatens patient safety but has a corrosive effect on morale, making life miserable for the nurses and residents who work closely with these physicians.

Dr. John D. Birkmeyer,³¹ an expert in patient safety, provided National Peer Review Corporation (NPRC) with his opinion regarding the relationship of disruptive conduct to patient safety.³² Discussing a recent Disruptive Provider Review conducted by NPRC (See Disruptive Provider Review on the National Peer Review Corporation website at www.nationalpeerreview.com), Dr. Birkmeyer noted:

This situation contains innumerable examples of disruptive conduct on the part of the Practitioner likely to pose direct threats to patient well-being and safety. These include evidence of condescending, abusive, and sometimes threatening language, particularly in his interactions with nursing staff. The Practitioner has created a climate of fear and distrust among staff involved in the care of his patients, which no doubt inhibits teamwork and the open, two-way communication among clinical team members that is essential for patient safety.

Such a climate substantially increases the risks of adverse outcomes for patients, both in the operating room and postoperatively. In the operating room, an OR nurse afraid of incurring the wrath of the Practitioner cannot function appropriately as a “second set of eyes” and may tend to be silent about breaks in sterile technique, inaccurate instrument/sponge counts, or other threats to patient safety. An intensive care nurse intimidated by the Practitioner will have a higher threshold to page him when a patient “just doesn’t look right,” and thus miss opportunities to diagnose and correct problems earlier. A floor nurse will be slower to call the Practitioner about non-urgent but nonetheless important things, like pain management.



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Although this Report does not attempt to tie the Practitioner's conduct to the outcomes of specific patients, a substantial literature establishes the relationship between communication and safety in surgical patients. In one study, for example, communication breakdowns among personnel were primarily responsible for 43% of adverse events occurring after surgery at 3 teaching hospitals in Boston.³³ In another analysis of 444 closed surgical malpractice claims, communication breakdowns were the second leading factor underlying adverse events, trailing only lack of technical competence.³⁴ A follow-up study based on the same patient population explored the nature of communication breakdowns leading to adverse events in surgical patients.³⁵ Attending surgeons were the most common team members involved; "status asymmetry" (e.g., between a surgeon and nurse) was an associated factor in 74% of cases. The most common communication breakdown involved failure to notify the attending practitioners of critical events, most of which occurred during the postoperative care phase.

More broadly, failures in communication and care coordination have been linked to higher mortality rates in the intensive care unit³⁶ and greater postoperative pain after surgery.³⁷ In another seminal study, Daley et al. conducted blinded site visits at 20 VA hospitals with particularly good or poor clinical performance in general surgery and vascular surgery (as reflected by risk-adjusted morbidity and mortality rates).³⁸ The former group of hospitals were distinguished by high measures of communication between the Practitioners and nursing staff; the latter by poor communication.³⁹

From the legal perspective, the Healthcare Quality Improvement Act of 1986 ("HCQIA") provides protection against money damages for practitioners and other health care professionals and for hospitals and other health care entities that engage in professional peer review. (See, also, Hospital Peer Review Guide I "Avoiding Money Damages" on the National Peer Review Corporation website at www.nationalpeerreview.com.) In addition to protection for taking action in response to conduct that has adversely impacted patient care, HCQIA contemplates a standard that permits hospital and medical staff decision-makers to act to prevent *potential* harm to patients. In *Gordon v. Lewistown Hospital*, the court stated:

[U]nprofessional conduct on the part of a physician is within the purview of a "professional review action" under the HCQIA. The plain language of the statute indicates the breadth of "conduct" encompassed within the definition of "professional review action" by the inclusion of conduct that "could affect adversely the health or welfare of a patient." 42 U.S.C. § 11151(9). The statute contemplates not only potential harm through use of the term "could," but it also affords protection to actions taken against physician conduct that either impacts or potentially impacts patient "welfare" adversely, meaning patient "well being in any respect; prosperity." Black's Law Dictionary (West Group, 7th Ed.1999). Even if the statutory language was deemed to be ambiguous, the legislative history would support the same construction. See Health Care



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Quality Improvement Act of 1986, H.R. 5540, 99th Cong. 2d Session (1986), 132 Cong. Rec. at 30768 (Oct. 14, 1986) (“competence and professional conduct should be interpreted in a way that is sufficiently broad to protect legitimate actions based on matters that raise concerns for patients or patient care.”). Other courts similarly have applied immunity in circumstances where a physician’s unprofessional “conduct” was an issue in the challenged professional review actions. See, e.g., *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 835 (3d Cir.1999) (affirming summary judgment in favor of Hospital afforded HCQIA immunity for peer review decisions involving a surgeon characterized as “a disruptive force in the hospital”); *Bryan v. James E. Holmes Reg’l Med. Ctr.*, 33 F.3d 1318, 1324 (11th Cir.1994) (granting immunity when physician’s privileges revoked for inappropriate and unprofessional behavior stemming from his “being a volcanic-tempered perfectionist, a difficult man with whom to work, and a person who regularly viewed it as his obligation to criticize staff members at [the Hospital] for perceived incompetence or inefficiency,” some of which occurred in front of patients about to undergo surgery); *Morgan v. PeaceHealth, Inc.*, 101 Wash.App. 750, 14 P.3d 773 (2000) (upholding immunity when physician’s privileges suspended for sexual harassment and inappropriate behavior with patients); *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461 (6th Cir.2003) (upholding immunity when physician’s reappointment denied because of failure to timely disclose disciplinary actions in another state, personality problem and various incidents of disruptive behavior); *Imperial v. Suburban Hosp. Ass’n*, 37 F.3d 1026 (4th Cir.1994) (affirming district court order granting summary judgment to hospital where physician’s reappointment to staff denied on basis of hospital’s conclusion that his professional activities did not meet standard of care, he was deficient in his record keeping, patient management, and work relationships with health care professionals at the hospital).⁴⁰

Unprofessional conduct affecting patient care was cited by the court in a 2007 California case:

Substantively, the evidence must demonstrate that Dr. Johnson’s behavior posed a realistic and specific threat to the quality of medical care at the facility (cite omitted). A private hospital may not permanently revoke or terminate a physician’s staff privileges based solely on the physician’s abrasive personality or inability to work with others (cite omitted). Instead, the physician’s behavior must be “such as to present a real and substantial danger that patients treated by him might receive other than a ‘high quality of medical care’ at the facility...

This standard was met here. The evidence as a whole showed that Dr. Johnson was abrasive and disrespectful to nurses and other staff to such an extent they were unwilling to work with him. Indeed, in the words of the JRC, Dr. Johnson’s behavior “complicat[ed] scheduling; delayed patient surgeries; and ... put patient lives at risk.”



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For example, on charge 4, the evidence showed that Dr. Johnson “behaved inappropriately and unprofessionally by yelling at a nurse” about the number of times he had been called about a patient. Kimmie Harden, a nurse, testified that she submitted the RIR underlying charge 4, the only RIR she had ever made against a doctor in her 16 years of working at the hospital. She made the report in part because Dr. Johnson was “ranting and raving” at the nurse’s station because the nurses had been calling him for orders regarding one of his patients... Ms. Harden said she had “never seen that kind of behavior at the nurses’ station by a doctor.”⁴¹

The safety of the patients is of paramount importance. If there is no evidence of the direct affect on patient care, a hospital is required to determine if the professional conduct of a physician threatens patient safety and *could* reasonably have a negative effect on patient care. If the hospital concludes that the professional conduct of a physician could reasonably have a negative effect on patient care, it is the duty of the hospital to take the appropriate preventative action.

The Joint Commission in the Sentinel Event Alert on July 9, 2008 titled “Behaviors that undermine a culture of safety”⁴² seemed to endorse this position when it stated:

Intimidating and disruptive behaviors can foster medical errors, (cites omitted) contribute to poor patient satisfaction and to preventable adverse outcomes (cites omitted), increase the cost of care (cites omitted), and cause qualified clinicians, administrators and managers to seek new positions in more professional environments (cites omitted). Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team...(cite omitted). Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients (cites omitted). All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

The Joint Commission developed a Leadership standard (effective January 1, 2009) that addresses disruptive and inappropriate behaviors in two of its elements of performance:

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

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



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However, it should be noted, that it is insufficient to reject, terminate or discipline a physician because the physician “annoys the other doctors nurses and administrators” (Nanawati⁴³), because the physician is a competitor (Patrick⁴⁴) or for other reasons that do not affect patient care.

One court concluded:

A hospital need not wait for a disruptive doctor to harm a patient before terminating his or her privileges. Nonetheless, more should be required than general complaints of a physician’s inability to cooperate with others. To constitute disruptive behavior meriting termination of staff privileges, hospital authorities should present concrete evidence of specific instances of misbehavior, such as unjustified altercations with other doctors or nurses, violations of hospital routines or rules, breaches of professional standards, or the commission of some other act that will adversely affect health care delivery (citations omitted).⁴⁵

2.4 Relevant Issues to a Peer Review of Disruptive Conduct

In all hospitals (and all workplaces) there are issues which are not resolved, not resolved to each physician’s satisfaction, or compromises that create tensions between physicians and staff. However these issues do not justify the unprofessional conduct of a practitioner.

The only issue for examination during a professional conduct review is the practitioner’s conduct. While the underlying causes are germane to a review of clinical or operational issues, they are largely irrelevant in determining if a practitioner’s conduct is unprofessional and if such conduct negatively affects patient care. In fact, focusing on the underlying causes, rather than the conduct itself, often results in delays and misdirection during the review.

In one case, the court noted:

Dr. Wieters does not contest the evidence of his outbursts and ill treatment of nurses. To bolster his claim that he was fired because he was a whistleblower, he submits evidence that conditions at the hospital were substandard. This evidence is irrelevant. Regardless of the merit of his complaints, the hospital presents uncontested evidence that he expressed them in a disruptive and unprofessional manner.⁴⁶



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2.5 Disruptive Provider Peer Review vs. Clinical Peer Review

Many hospitals initially investigate the clinical practice of a disruptive, marginally competent provider, rather than attempt a review of the physician's disruptive conduct. The rationale includes political concerns and motivations, as well as other factors that infuse the behavioral review process with an actual or perceived aura of subjectivity. A clinical peer review, it is argued, provides the hospital with a clearer basis for taking action.

This appears to be a sound approach, if there are, in fact, clinical competency issues that are actionable. If not, the clinical peer review becomes one more unnecessary, resource consuming, why-aren't-they-doing-something, why-am-I-being-singled-out step in attempting to handle the disruptive provider.

Tackling the problem of disruptive behavior head-on, through objective investigation and reporting, is clearly more effective in addressing and preventing disruptive behavior than skirting the issue with a clinical peer review.

3. Failure to Establish Standards for Professional Conduct

Medical staff and administration decision-makers hesitate to initiate a review of certain physicians alleged to be “disruptive physicians.”

One reason for this hesitancy is that many hospitals do not have clear, established standards for professional conduct and, as a result:

- Politics at the hospital usually overrides action.
- The medical staff leadership and administration sidestep the problem unless the conduct is particularly egregious or potentially embarrassing.
- The peer review participants often find the evidentiary basis for the review to be too subjective to support a peer review action.
- Differing interpretations of the conduct by the alleged disruptive providers prevents action.
- An “us versus them” mentality may drive defensive viewpoints of the medical staff.
- Physicians and the staff tend to “work around the problems” because they are aware that disciplinary action will be avoided.

Hospitals cannot ignore the legal obligation to investigate and take action to protect the safety of patients and the hospital staff from the disruptive conduct of a physician. Eventually, if this conduct persists, it is likely that the EEOC or the judicial system will act and impose liability on the hospital for this failure. Rather than sidestep the problem until the EEOC or the legal system imposes a solution and possibly money damages, the hospital should be proactive in instituting standards of conduct and enforcing those standards through the peer review system.



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With standards of professional conduct in place, each physician is on notice that:

- The leadership has determined that certain conduct will not be tolerated at the hospital.
- Compliance is required.
- The standards cannot be disregarded if the physician intends to continue to practice at the hospital.
- Each physician will be uniformly judged, through the peer review system, based upon these standards.

4. Labor Law Issues in Medical Staff Cases

Hospitals should consider involving legal counsel with expertise in labor law when handling disruptive providers.

For example, if a physician is reported for sexual harassment or other employment issues, the hospital may determine that a reprimand is sufficient based upon the medical staff bylaws and the laws relating to medical staff matters. However, applicable labor laws may require stronger sanctions, such as suspension or even termination. As a result, the hospital and members of the Medical Executive Committee of the Medical Staff could be exposed to liability, including personal liability, for failing to take appropriate disciplinary action.

In order to avoid unnecessary exposure to liability, medical staff legal counsel should consult with a labor relations attorney when necessary. Once the advice of the labor relations attorney has been obtained, the medical staff attorney may guide the case appropriately through the due process requirements of HCQIA and the medical staff bylaws.

5. Delay of The Peer Review Process and Its Impact on Patient Care

5.1 Restraint of Actions by the Hospital to Protect the Physician Often Results in Delay

Hospital and medical staff decision-makers (and the courts) recognize the importance of maintaining medical staff privileges to a physician's livelihood. Adding to this sensitivity is the actual and perceived degree of subjectivity often involved in investigating the disruptive conduct of a physician.



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Therefore, in most instances, as reflected in the case law, hospitals and colleagues on the medical staff usually exercise restraint and extreme caution when initiating and proceeding with professional review actions against disruptive physicians. This often results in a delay in dealing with the disruptive physician. Examples of restraint which create delay include:

- Informal discussions, recommendations and warnings
- Political and economic pressure
- Long periods of inaction
- Multiple “official warnings” without significant consequences
- Delays in initiating the peer review process
- Delays in the actual conduct of peer review and peer review investigations
- Multiple meetings and corresponding promises to behave by the disruptive physician
- Reluctance to use peer review as education
- Reluctance to suspend a physician
- Reluctance to use external peer review to determine the effect of the physician’s conduct on patient care
- Delay in involving legal counsel

Although intended to protect the rights and livelihood of the disruptive physician, the delay caused by such restraints and cautions inevitably disturbs the normal operations of the hospital and, thereby, adversely affects patient care. In addition, delay usually makes any future professional review action more difficult for both the hospital and the physician.

5.2 Delays Increase the Potential Liability of the Hospital

Delays in taking actions regarding a disruptive physician can create significant exposure to liability for the hospital and may limit its ability to effectively pursue a professional review action.

Allowing the physician under investigation to continue to practice during the delay may:

- Result in continued disruptive conduct by the physician and its adverse affects patient care, which may legally be attributed to the hospital.
- Infer that the hospital believes that the disruptive conduct is relatively unimportant, thereby damaging the hospital’s standing with the medical staff and its position in a professional review action.



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Not allowing the physician under investigation to continue to practice during the delay may also result in liability for the hospital. If a case initiated by the physician is prejudiced by the fact that the hospital did not allow the physician to practice during the delay, the hospital may be subject to money damages if the hospital failed to follow the requirements of HCQIA or applicable state law.

In either case, the delay alone has created additional potential liability for the hospital. By taking timely and effective peer review action to address reported disruptive conduct, the hospital can avoid this liability.

In addition, timely peer review action can preserve the hospital's ability to gather credible evidence of continued disruptive conduct. If the hospital and the medical staff decision-makers delay the process, the other physicians, nurses and hospital staff frequently stop filing complaints against the disruptive physician out of fear of retaliation or the belief that the hospital and the medical staff decision-makers are not willing to take action. Therefore, once the professional review action is initiated, the hospital and medical staff decision-makers may be forced to explain gaps in complaints against the disruptive physician.

5.3 The Affect of Delay on the Normal Operations of the Hospital

Permitting a physician to continue to exhibit disruptive conduct may create a hostile environment that can adversely affect patient care and hinder the ability of the hospital to retain and recruit nurses and other staff. With respect to the nursing and other staff who directly deal with the disruptive physician, the delay by the hospital and medical staff (seen as inaction by the staff) may cause nurses and other staff to:

- quit (i.e., nursing shortage)
- be afraid to clarify the orders of the disruptive physician
- be fearful of calling the disruptive physician regarding patient care
- hesitate to act from fear of criticism from the disruptive physician
- fear retaliation for "writing-up" a disruptive physician or reporting disruptive activities to a supervisor

Although nurses and other staff are usually the primary victims of a physician's disruptive conduct, colleagues on the medical staff are not immune. Disharmony among the medical staff usually has an adverse effect on patient care. As a result of a disruptive physician's conduct, other physicians on the medical staff may:

- avoid taking call for the disruptive physician
- avoid consulting with the disruptive physician
- hesitate to act from fear of criticism by the disruptive physician
- hesitate to report the actions of a disruptive physician due to fear of retaliation



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5.4 The Affect of Delay on Physician Education

Peer review is an effective, established procedure for upgrading a physician's clinical knowledge, enhancing his/her medical practice, reducing medical errors and improving patient safety. Too often, peer review is seen as a confrontational process designed solely to discipline physicians.

The key to effective educational peer review is early detection and prompt action to re-educate the physician.

If the hospital acts with a sense of urgency and avoids delay, most physicians are receptive to education and appropriate adjustments to clinical practice patterns and conduct. Delay may exacerbate the situation to such an extent that adversarial remedial action becomes necessary. The issues, which may have been resolved earlier by education, can subsequently only be resolved by confrontation.

6. Clinical Competence and Disruptive Conduct

If the hospital and medical staff are concerned about a physician's clinical competence, as well as disruptive conduct, the peer review activities for each issue should be conducted as two separate tracts – a clinical review to determine the physician's clinical competence and a disruptive provider review to investigate the physician's disruptive conduct.

Dividing the peer review into two distinct issues keeps the peer reviewers and investigators focused on the issues within their expertise and ensures the credibility of the report of each type of review. If either report concludes that the physician's actions adversely affect patient care, the hospital will have a foundation for taking appropriate action.

6.1 Clinical Review

The clinical review should be conducted as follows:

- A credentialed peer reviewer, board certified in the same specialty as the provider, reviews a sampling of cases to determine if the care rendered by the physician satisfies accepted standards of care.
- The peer reviewer provides clear and concise findings and conclusions regarding the medical management of the cases and notes any deviations from comparative data, benchmarks and accepted national standards.
- Depending on the number of cases reviewed, the findings are aggregated and patterned.
- Variations from expected outcomes or practice patterns are analyzed for their actual and/or potential effects on patient outcomes.
- The findings include references to current medical literature and comparative data, benchmarks and accepted standards of care.



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6.2 Disruptive Provider Review

The disruptive provider review should be conducted as follows:

- The hospital records relating to the professional conduct of the physician, including the credentialing file, staff complaints, and records of investigation, committee minutes and other relevant information, are reviewed.
- This information is abstracted, organized and prioritized to determine the appropriate conduct of an investigation.
- Information regarding the physician's professional conduct is gathered during the investigation through interviews with the physician's peers, patient care professionals, managers, administrators, technical and support personnel.
- Based upon this information, a record detailing any disruptive conduct incidents, their causes, targets and the circumstances surrounding these incidents is created.
- The information should be analyzed to determine if there is objective, clear and convincing documentation of disruptive conduct by the physician and evidence demonstrating that such conduct adversely affects patient care.

This two-track approach keeps the peer reviewers and investigators focused on the issues within their expertise. A single peer reviewer conducting both the clinical competence and the professional conduct review often expresses opinions that are not within his/her expertise (e.g., an orthopedic surgeon analyzing the mental condition of the disruptive physician). These opinions are subsequently incorporated into and become an intractable part of the peer review report. As a result, during a hearing or in subsequent litigation, the extraneous opinions and the professional qualifications of the peer reviewer to support such opinions become a diversion from the issues of clinical competency, professional conduct, and the impact on patient care.

7. Tactics of The Disruptive Physician Which Delay Peer Review Actions

In many instances the delay by the hospital and the medical staff decision-makers in taking peer review action against a disruptive physician are the result of the defensive tactics used by the disruptive physician. The following are some of the usual tactics used by the disruptive physician and the appropriate responses to such tactics by the hospital and the medical staff decision-makers.



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7.1 Threat of Litigation

The physician threatens litigation if the medical staff and the hospital proceed with a professional review action.

Hospital and Medical Staff Response

The threat of litigation should not deter the hospital and the medical staff from proceeding in accordance with the medical staff bylaws.

If the hospital and the medical staff proceed against the physician in the reasonable belief that the action was in the furtherance of quality health care in accordance with HCQIA and the medical staff bylaws, they are immune from damages.⁴⁷ There is no such immunity from patient litigation.

7.2 An Injunction

Physician engages legal counsel and seeks an injunction from a court.

Hospital and Medical Staff Response

The hospital and medical staff should resist an attempt for an injunction. Courts are reluctant to intercede in professional review actions. The courts usually avoid determining if the conduct of a physician affects patient care and defer such decisions to the hospital and the medical staff.

In most cases the court will require the physician to exhaust remedies under the medical staff bylaws and hospital bylaws. After these remedies are exhausted, the physician may initiate litigation based upon HCQIA and other causes of action. However, if litigation is initiated at this time, compliance with the due process procedures of HCQIA and the medical staff bylaws puts the hospital and the medical staff in a position to successfully move to dismiss the case based upon HCQIA.

7.3 Allegations of Conspiracy

The physician alleges that the professional review action is the result of a conspiracy among competitors or other members of the medical staff or the nursing staff to remove the physician from the medical staff.⁴⁸

Hospital and Medical Staff Response

Legitimate professional review actions may result from a union of other physicians on the medical staff or nurses to remove a disruptive physician. Competitors may be energized to instigate a professional review action because they best recognize the adverse affect of the physician's disruptive conduct on patient care and safety.



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In the case of nurses, they are often the victims of abusive conduct. Therefore, nurses will often unite to protect patients or themselves from a physician's disruptive conduct.

Despite these legitimate concerns and actions, a disruptive physician will perceive these unions of colleagues or nurses as a conspiracy based solely upon anti-competitive motivations or personal dislike.

The allegations of conspiracy should not deter the hospital and medical staff from dealing with the alleged disruptive conduct. The best response is to inform the accused physician that the defense of conspiracy may be asserted during the impartial due process procedures provided by the medical staff bylaws.

An objective, external peer review investigation of the cases at issue may assist the hospital and medical staff in defending against charges of conspiracy by the physician.

7.4 Allegations of Being Singled Out for Discipline

The physician alleges that other physicians behave in the same manner. The physician claims to have been singled out for punishment.

Hospital and Medical Staff Response

The hospital and the medical staff should inform the physician that the professional review action is an investigation only of the physician. If, after due process, the conduct of the physician is found to have an adverse affect on patient care, appropriate action will be taken. It is not a defense that others are guilty of the same conduct.

However, the physician should be requested to provide written formal complaints and evidence regarding the other physicians on the staff. Then, the hospital and the medical staff should, if merited, conduct professional review activities regarding these allegations.



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7.5 Disruptive Conduct is Actually Patient Protection

The physician being accused of disruptive conduct, such as verbal abuse to other physicians and nurses, claims that this conduct is for the protection of the patients. The disruptive physician claims to be protecting the patients from the clinical incompetence of the other physicians or nurses (particularly those physicians and nurses filing complaints with the hospital).⁴⁹

Hospital and Medical Staff Response

The professional review activities regarding the physician should continue. Evidence of substandard patient care is not relevant to the issue of a physician's disruptive conduct. As quoted above, one court stated:

Dr. Wieters does not contest the evidence of his outbursts and ill treatment of nurses. To bolster his claim that he was fired because he was a whistleblower, he submits evidence that conditions at the hospital were substandard. This evidence is irrelevant. Regardless of the merit of his complaints, the hospital presents uncontested evidence that he expressed them in a disruptive and unprofessional manner.⁵⁰

The disruptive physician should be requested to provide formal written complaints regarding the allegations against the other physicians and nurses. If merited, the hospital and medical staff should commence the procedures required by the medical staff bylaws and the rules and regulations of the hospital to investigate the allegations.

7.6 Political Activity

Asserting that "if they can do this to me they can do this to you," the disruptive physician may attempt to unite the other physicians against the medical staff officers and committees and the hospital.

Hospital and Medical Staff Response

Using the mechanisms provided in the medical staff bylaws, particularly the MEC, the medical staff officers and hospital administration should build a consensus among the members of the MEC and appropriate committee chairs regarding pursuing a professional review action against the physician.

Upon obtaining a consensus of the physicians on the MEC and the committee chairs, outside peer review should be obtained to provide an objective basis for any professional review action. Once properly in motion, the professional review action will be difficult to thwart by political moves.



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Conclusion

Failure to investigate and take appropriate action when a physician is disruptive ignores the legal obligation of the hospital to protect its patients and its operational objective to create a safe and pleasant environment for its staff.

The courts have clearly determined that a hospital may take appropriate action against a disruptive physician when an objective investigation yields:

- Clear and convincing documentation of the disruptive conduct; and
- Evidence demonstrating that such conduct adversely affects patient care.

This documentation and evidence, together with the conclusions and recommendations of the peer review, should be contained in a comprehensive, fully documented, practical report that will serve as the foundation of any action or inaction by the hospital regarding the physician under review.



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Footnotes

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- 46 *Wieters v Roper Hospital., Inc.*, No. 01-2433 (4th Cir. Feb. 27, 2003)
- 47 *Wei v. Bodner*, 983 F.2d, 1054 (3d Cir. 1992). The United States District Court for the District of New Jersey awarded hospital and physician costs and attorneys' fees under Rule 11 of the Federal Rules of Civil Procedure and HCQIA to a hospital that terminated a physician after a long history of inappropriate behavior. The court found that the physician failed to "stop, think, investigate and research before dragging defendants into federal court."
- 48 *Rooney v. Medical Center Hospital of Chillicothe*, 1995 WL 437548 (S.D. Ohio 1995). The hospital terminated a physician's medical staff appointment and privileges following several attempts to curb the physician's disruptive and uncontrollable temper. The physician sued the hospital, individual trustees and other involved in the peer review process alleging that they engaged in conspiracy in violation of the antitrust laws. The federal court granted summary judgment to all defendants, ruling that they were immune from liability under HCQIA. The physician was ordered to pay the defendant's costs and attorneys' fees under Section 11113 of HCQIA.
- 49 *Blau v. Catholic Healthcare West*, No. B157516 Super. Ct. No. BC250166 (Cal. Ct. App. Feb. 27, 2003). Following charges of harassment, intimidation and other forms of verbal abuse by the physician, the Medical Center found the physician's behavior disruptive, that his conduct was making the employees physically ill and undermining morale, and that he was making improper entries in patient charts as a means to complain about his dissatisfaction with the hospital's staff and equipment. The physician claimed that he was acting out of concern for patient care.
- 50 *Wieters v Roper Hospital., Inc.*, No. 01-2433 (4th Cir. Feb. 27, 2003)