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Responding to Disruptive Practitioners: Pitfalls and Tips

By Lowell C. Brown

Many of my fellow peer review lawyers and I have noticed that disruptive practitioner behavior, once a fairly rare phenomenon, seems to have become a regular occurrence in our clients' world. Once, physician and hospital leaders faced a serious behavioral problem among their physicians only occasionally; it now seems that most physician discipline cases include at least one element of seriously disruptive behavior. Along the way we have learned some things that may make it easier for hospitals, health systems, and provider groups to deal with such troublesome and trying matters.

All such discussions must begin with a definition of what we are talking about. The American Medical Association Disruptive Practitioner Policy defines disruptive behavior as ''a style of interaction with physicians, hospital personnel, patients, family members, or others **that interferes with patient care**.'' (Emphasis added.)

That last concept in the AMA definition is important. In most states, a physician's behavior will not be grounds for corrective action unless a connection can be drawn between the behavior and patient care. (*See Miller v. Eisenhower Medical Center*, 27 Cal. 3d 614, 614 P.2d 258 (1980).) In other words, simply being difficult, boorish, or impolite is not enough; patient safety must be in jeopardy as a result.

With that in mind, here are some questions peer reviewers should ask themselves as they prepare to deal with their own disruptive practitioners.

1. **Does your state have a whistleblower statute?** In order to encourage health care providers—whether physicians, nurses, or others—to report unsafe conditions in hospitals, many states have statutes encouraging whistleblower activity. For example, California's Health & Safety Code § 1278.5 recently was expanded to include physicians among those protected from retaliation for bringing to light unsafe practices or conditions. In fact, California's Supreme Court is scheduled to hear a case about that statute, and whether it allows physicians to circumvent the statutory procedures for peer review hearings by going straight to court with a whistleblower lawsuit. (*See Fahlen v. Sutter Central Valley Hospital*, 208 Cal. App. 4th 557, 145 Cal. Rptr. 3d 491 (Cal. App. 2012); (21 HLR 1250, 8/30/12); *review granted*, 149 Cal. Rptr. 3d 614, 288 P.3d 1237 (Cal. 2012)). We will have more about the *Fahlen* case in a future Counsel's Corner article.

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If there is a whistleblower statute, it is important that any complaint by a physician be carefully investigated and taken seriously. In the end, documentation of that careful response to a complaint will be necessary to rebut a spurious whistleblower claim.

2. **Do you have a code of conduct?** Since 2008, the Joint Commission has enforced leadership standard LD 03.01.01, which added Elements of Performance 4 and 5. The requirements now are that a hospital ''has a code of conduct that defines acceptable and disruptive and inappropriate behaviors'' and that ''health care facility leaders create and implement a process for managing disruptive and inappropriate behavior.''

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Working with legal counsel, medical staffs and hospitals should ensure that a code of conduct is in place that covers not only hospital employees but also medical staff. This set of requirements belongs in the medical staff bylaws, not in a general policy. Otherwise, physicians may claim that a policy for hospital employees is not applicable to them, especially in states where physicians are not hospital employees. The bylaws provisions regarding a code of conduct should specify how that set of rules integrates with the other bylaws provisions on corrective action, so that when behavior that violates the code of conduct rises to the level of formal corrective action, medical staff leaders have clear grounds for acting.

3. **Do you routinely use early intervention?** Most experienced peer reviewers will tell anyone who listens to them that the earlier a behavior problem is addressed, the easier it will be to resolve. Ideally, the chief of staff and another medical staff leader (or the chief medical officer) would interview a physician whose behavior has been questioned. The meeting's purpose would be to form an alliance with the physician, if possible. The physician should receive a written summary of the behavioral issues identified and of the agreed-upon action plan going forward. Of course, the plan resulting from the meeting must be enforced; such efforts are meaningless in the end if there is no follow-through and the medical staff leaders do not insist on accountability.

4. **Should you use a behavior contract?** Behavior contracts, which are allowed under many medical staff bylaws, serve several purposes.

- They give the physician fair warning that the physician's behavior has now reached the point where corrective action will be taken unless the physician complies with the contract.
- They provide standards for the physician's behavior.
- Perhaps most important from a legal point of view, they put the medical staff leadership in a position to take corrective action if necessary.

Once a behavior contract is in place, it must be enforced. Perhaps the worst thing medical staff leaders can do is to insist that a physician sign a contract, and then act as if the contract did not exist. That will send an unfortunate and unmistakable message to the physician involved, as well as to others who are watching: that the medical staff lacks the will to follow through.

Consistent with state law requirements, the contract should recognize due process rights and include clear provisions about the type of hearing that a physician will receive in the event the physician violates the contract and corrective action is initiated. Of course, any behavior contract also must be consistent with the medical staff bylaws.

Hearings involving disruptive practitioners, it should be noted, usually are the most difficult of all because of the nature of the personalities involved. Therefore, the contract should set forth a fairly narrow and efficient process for any hearing that might result.

Disruptive behavior is among the most vexing of disciplinary actions facing leaders of physicians and other licensed practitioners. By confronting the problem directly using some of the suggestions outlined above, medical staffs and other provider groups can make dealing with such issues easier and much more legally defensible.

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