
HALL RENDER
KILLIAN HEATH & LYMAN
Illinois State Medical Society
Disruptive Behavior
Critical Practices to Employ Every Time
MEDICAL STAFF
SEMINAR 2023
PRESENTED BY HALL RENDER'S MEDICAL STAFF SERVICES TEAM
DECEMBER 7-8, 2023

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HALL RENDER
KILLIAN HEATH & LYMAN

Presenter Info

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Agenda

- Hypothetical #1 – You are the MEC!
- Potential Impact on Quality of Care
- Establishing a process to address problematic behavior
- Critical elements in relation to that process
- Hypothetical #2
- Takeaways

Hypothetical #1

Hypothetical #1

- Independent Physician (i.e., not employed by Hospital) has a known history of unprofessional behavior directed toward staff (yelling, rude, demeaning comments) over his 10-year history at Hospital.
- Three separate Department Chairs (over this period) have "collegially" discussed this behavior with Physician.
- The third "collegial" discussion followed a written complaint submitted by a nurse (via email) to the nurse's manager.
- There is no documentation by the Department Chairs of the "collegial" discussions.
- Last week, Physician was involved in an altercation at a local bar. Physician punched a waiter following a dispute regarding Physician's bill. This is not in dispute.
- Security detained Physician and called local Police. Local Police arrested Physician. Physician has been charged with (a) public intoxication and (b) assault/battery.
- A witness had video recorded the event on her iPhone; the video has been posted to social media; the video clearly shows Physician yelling at the waiter and then striking the waiter (video also shows no physicality by waiter)
- The above details/video are reported to Hospital CEO, who refers the matter (including video) to MEC
- MEC meets via special meeting to receive/consider this information
  - What should MEC be considering?
  - Should MEC address this scenario?
  - If so, outline what steps the MEC should consider/take to address the matter

Disruptive Behavior Can Impact Quality of Care

- Joint Commission (2008)

"Behaviors that undermine a culture of safety":

"Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. 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."

Potential Impact on Quality of Care

Joint Commission (continued):

- Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities

- Overt and passive behaviors each undermine team effectiveness and can compromise the safety of patients
- All intimidating and disruptive behaviors are unprofessional and should not be tolerated

Disruptive Behavior

- What type of behavior may constitute “Disruptive Behavior”?
  - Lound, threatening or abusive language (active or passive)
  - Degrading, demeaning, or condescending language/comments
  - Refusal to answer questions, telephone calls, or pages
  - Chronically late
  - Derogatory comments about the quality of care provided by other physicians, nursing personnel or the hospital
  - Inappropriate medical records entries
  - Sexual harassment, comments, innuendoes
  - Racial, ethnic or socioeconomic slurs
  - Threats of violence, retribution, retaliation, etc.

What generally is not Disruptive Behavior?

Examples:

- Following established processes to report complaints or address concerns
- Constructive criticism (intended to foster improvement)
- Protected whistleblower activity
- Identifying and attempting to collegially resolve demonstrable quality issues
- Respectfully expressing personal political views or other differences of opinion

Prevalence & Trends

- In a recent survey of physician executives:
  - 95% reported regularly encountering disruptive physician behavior.
  - 70% said disruptive behaviors nearly always involved the same physician(s).
  - Nearly 80% said disruptive physician behavior is under-reported because of victim fear of reprisal or is only reported when a serious violation occurs.

Recognizing the Risks

- Reluctance of staff to interact with disruptive physicians
  - Not seek clarification of orders
  - Not want to call for instructions
  - Not want to call to provide information
  - Reluctance to question inappropriate orders, actions, or other errors
  - Reluctance to bring errors to physician's attention
- Institute for Safe Medication Practices:
  - 40% of clinicians reporting remaining quiet rather than confront known intimidator
  - 75% had asked a colleague to help interpret an order to avoid interacting with an intimidating prescriber

Recognizing the Risks

- Decline in Employee Morale
  - Can mask non-compliance
  - Reluctance of staff to challenge non-compliant conduct
  - Reluctance to report non-compliant conduct
  - Eventual silence is often a negative indicator
- Litigation Risk
  - Hostile work environment
  - “Bullying”/Emotional Distress (Example)
  - Constructive discharge
  - Sexual harassment (Example)
  - Challenge by Subject Physician

Recognizing the Risks

- Risks to Reputation/Confidence
  - Inappropriate conduct is often witnessed by patients/families
  - Erodes the community's confidence in the Hospital's and Physician's ability to provide quality patient care
  - Also risks damaging Hospital's and Physician's reputation among health care providers

"Jurisdiction"

- Unprofessional Conduct is not strictly limited to behaviors that occurs within the Hospital
- May consider behaviors that have occurred outside of the Hospital when bear on character, confidence, hospital operations, etc.
- Basic eligibility requirements:
  - Include "acceptable character, competence, training, experience, background, and judgment…"
  - Criminal history
  - Excluded provider status

Medical Staff – Key Role

- The organized Medical Staff has primary responsibility, to the Board, for the quality of care provided in the Hospital
- Critical functions include (but are not limited to):
  - Credentialing
  - Quality Review
  - Corrective Action
- Monitoring for and addressing clinical competency concerns and unprofessional conduct concerns is critical to this role

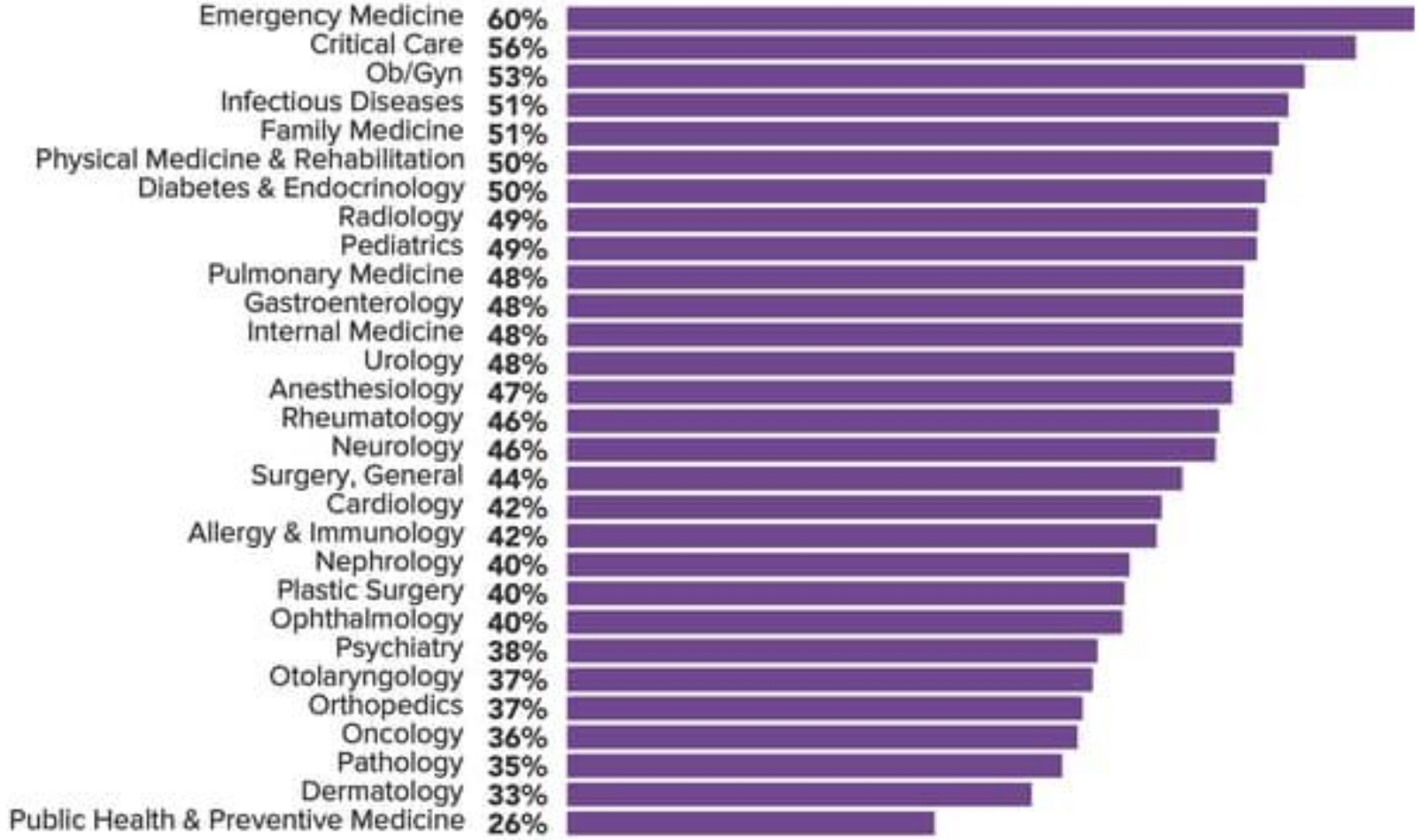
Medical Staff "Peer Review" Process

- Medical Staff should address "professional conduct" as part of a legitimate peer review processes
- Federal regulation ("HCQIA") clarifies that the Medical Staff's "professional review" obligations extend to both clinical competency **and professional conduct** concerns, which may adversely impact the quality of care
- Remember – "Peer Review" benefits include:
  - Peer Review **Immunity**
  - Peer Review **Confidentiality**

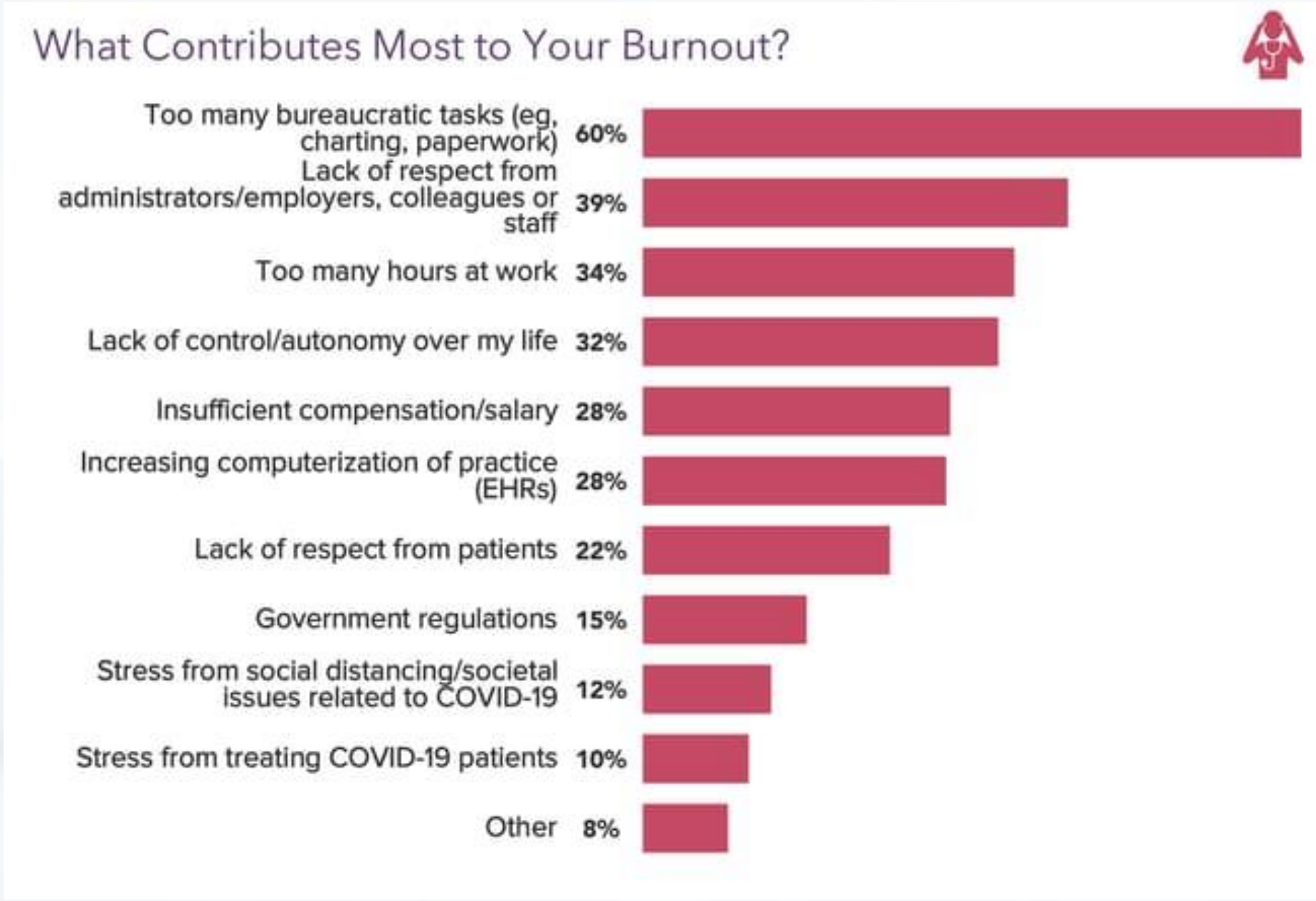
Process Considerations

- Step One: Have a Policy/Process to address Unprofessional Conduct that sets forth clear expectations
  - What constitutes unprofessional conduct
  - What does not constitute unprofessional conduct
- But also consider potential preventative measures
  - Orientation/Mentoring/Coaching
  - 360-degree reviews
  - Education/communication
  - Burnout concerns/wellness programs

Which Physicians Are Most Burned Out?



What Contributes Most to Your Burnout?



Addressing Problematic Behavior

- The applicable “process” will typically be addressed through both a Medical Staff Policy and the Medical Staff Bylaws
  - Professional Conduct Policy (defines behaviors, initial review process, remedies that do not restrict the ability to practice, and potential referral to MEC)
  - Medical Staff Bylaws (include more formal process for potential corrective/adverse action)

Addressing Problematic Behavior

- Process should be sufficiently simple/flexible
    - Define clear roles
    - Have outlet for “summary action” (per Bylaws) when required
    - Example
- Process should be consistently/evenly applied
- Process should contemplate early intervention
    - The earlier problematic behavior is addressed, the greater the opportunity for resolution

Addressing Problematic Behavior

- The process for addressing problematic behavior should, when possible, be progressive in nature
  - Affords greatest chance of success
  - Affords more protection when there is not success
- Where you start in the process depends on where you have been:
  - Is this a long-time offender who has never been approached?
  - Is this a repeat offender who is not responding to informal efforts? Or is this a first-time offender?

Addressing Problematic Behavior

- When engaging the process, it is critical to promptly consider/explore the cause of the behavior:
  - Circumstances – financial, personal, burnout
  - Impairment – drugs, alcohol
  - Psychological issue – depression, personality disorder
  - Other….
- The best action to address disruptive behavior will inherently depend on the cause of the behavior
  - Consider need for external evaluation early in the process
  - Ensure that external review is sufficiently complete/meaningful

Recommendations – Process

- Documentation is **critical** (even when considered "collegial")
  - Considerations for turnover
  - Considerations for evidence/witnesses
- When concerns are raised and process is employed:
  - Meet in-person (promptly)
  - The "intervention" process is critical
    - Medical Staff process requires participation of Medical Staff
    - Explore the nature of the behavior
    - Is the practitioner even aware of his/her behavior?
    - Reference the process
    - Communicate clear expectations and plan of action
    - Do not lose to follow-up

Recommendations – Process

- Credentialing and Re-credentialing:
  - Credential new applicants carefully
    - Gaps in employment/medical staff history
    - "Voluntary resignations"
    - Prior reported concerns/other red flags (dig deeper)
    - Dates, circumstances, etc.
    - Remember the initial applicant bears the burden of proving qualifications
  - Re-credentialing
    - Evaluate prior to two years
    - Evaluate results of OPPE
    - Ensure peer review committees are (appropriately) sharing relevant information

Recommendations – Process

- Considerations for Corrective Action:
  - **Remember**: Peer Review Immunity assumes a **reasonable investigation**
    - Is this a pattern of conduct or an egregious/isolated occurrence?
    - Consider past collegial intervention, investigations, actions
    - Review the pertinent documentation
    - Speak with the relevant witnesses
    - Consider need for outside review/evaluation
      - Medical Staff Committee should dictate (or minimally approve) this process
      - Address authorizations/releases up front
  - Follow your process and document compliance and investigation
  - Identify what rules have been violated and how

Recommendations – Process

- Considerations for Corrective Action:
  - **Remember**: Peer Review Immunity assumes a **reasonable action**
    - Measured, proportional responses
    - Progressive action is preferred (when it is possible)
    - Document rationale for action
    - Consider timing of summary suspension (if applicable)
    - Address retaliation
  - Be careful with timing of summary suspension (if applicable)
  - Be careful to appropriately address claims of disability
  - Recognize fair hearing rights if “adverse action” is recommended

Hypothetical #2

Hypothetical #2

- Independent Surgeon (with no pre-existing history of concerns) is observed on multiple occasions acting in an "unusual" manner.
  - Has seemed "confused" during a few recent cases
    - Unusual intraoperative pauses/asked for incorrect surgical instrument
    - Longer surgery times in these cases than usual
  - Forgot a patient's name last week
  - Has recently been lashing out at nursing staff
- There have been no complications during these cases.
- OR Manager is advised of these concerns and relays the concerns to the Department Chair.
- Department Chair promptly reports these concerns to MEC at its next meeting.
- What should MEC do?
  - Should MEC address this scenario?
  - If so, outline what steps the MEC should consider/take to address the matter?
    - Should one of these steps involve a third-party evaluation of Surgeon?
    - Is MEC permitted to request this type of evaluation?
- What if Surgeon was employed by the Hospital? Should this alter MEC's approach?

Special Considerations – Late Career

- Data suggests general decline in cognitive ability, manual dexterity, and visuospatial ability with increasing age – but that the nature/extent of this decline is highly variable
- “[B]etween ages 40 and 75 years, the mean cognitive ability declines by more than 20%, but there is significant variability from one person to another, indicating that while some older physicians are profoundly impaired, others retain their ability and skills." Jama Surg. 2017; 152(10)

Late Career Practitioners

- Study compared the performance of three groups of surgeons
  - Younger group (ages 20 to 35 years) outperformed the mid-career group (ages 46 to 60 years) and the mid-career group outperformed the senior surgeons (ages 61 to 75 years) in reaction time, rapid visual information processing, and the visual paired associates learning tasks.
- However, when surgeon group performance was compared with age-matched controls, the surgeon groups performed significantly better than the non-surgeons of the same age.

Late Career Practitioners – Literature

- **Cognitive Testing of Older Clinicians Prior to Recredentialing** (JAMA Performance Improvement, January 14, 2020)
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5431772/?report=printable
- https://www.acpjournals.org/doi/10.7326/0003-4819-142-4-200502150-00008
- https://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/84365
- https://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/78716
- https://www.empr.com/home/features/should-aging-physicians-be-required-to-undergo-cognitive-testing-three-experts-weigh-in/2/
- https://journalofethics.ama-assn.org/article/competence-not-age-determines-ability-practice-ethical-considerations-about-sensorimotor-agility/2016-10
- https://www.medscape.org/viewarticle/899970
- https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1629&context=healthmatrix
- https://www.healthleadersmedia.com/clinical-care/when-doctor-too-old-job
- https://www.medpagetoday.org/publichealthpolicy/generalprofessionalissues/84520?vpass=1
- https://www.nytimes.com/2011/01/25/health/25doctors.html?auth=login-email&login=email
- https://www.mja.com.au/journal/2008/189/11/knowing-or-not-knowing-when-stop-cognitive-decline-ageing-doctors
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4083243/pdf/nihms500531.pdf
- https://journals.lww.com/academicmedicine/Fulltext/2002/10001/The_Aging_Physician__Changes_in_Cognitive.2.aspx
- https://journals.lww.com/academicmedicine/Fulltext/2006/10000/Competence_and_Cognitive_Difficulty_in_Physicians_.14.aspx

Options to Address

- Options most commonly employed to address concerns regarding late career practitioners
  - Mandatory Retirement at Defined Age (**NOT RECOMMENDED**)
  - Mandatory Screening/Testing at Defined Age (**IN LITIGATION**)
  - Ongoing Quality Review with Responsive Professional Health Investigation/Action
- Joint Commission guidance/standards = Option 3 (utilization of ongoing quality review)

Takeaways

- Disruptive behavior does (or has the distinct potential) to impact the quality of patient care
- Have a ("peer review") process to address disruptive behavior
- Know your role in the process and follow the process
- In doing so:
  - Address disruptive behavior early
  - Identify the cause of the behavior
  - Take appropriate action (pursuant to your process)
  - Document (even when "collegial")

Questions?

Contact Us

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