

LEGAL ENTANGLEMENTS IN DEALING WITH DISRUPTIVE BEHAVIOR

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In this article...

A study looks at cases of disruptive behavior that ended up in state and federal courts and the most common reasons why legal action was taken.

WE FIRST REPORTED ON THE RESULTS OF OUR

research on the incidence and consequences of physician disruptive behaviors in the *Physician Executive Journal* in 2002.¹ Since that time, hundreds of other surveys and reports have documented concerns about the negative impact of disruptive behaviors on staff relationships, job performance, communication gaps and the occurrence of adverse patient outcomes of care.

Despite efforts to highlight the significance and consequences of disruptive behaviors, many organizations still struggle with efforts to develop, implement and enforce appropriate policies, procedures and intervention strategies to curtail these disturbing activities.²⁻⁴ The problem is further exacerbated by the growing amount of complexity, stress, burnout and other challenges imposed by today's changing health care environment.⁵⁻⁷

In order to effectively address these issues organizations need to:

1. Understand and define what disruptive behavior is.
2. Define standards with set criteria for acceptable and unacceptable behaviors.
3. Outline ramifications for noncompliance.
4. Develop clearly defined policies and procedures.
5. Implement a comprehensive process for reporting, investigation and review.
6. Develop a consistent unbiased objective approach

for intervention, action planning, documentation and follow-up recommendations.

Failure of physicians to comply can lead to legal involvement in the way of disciplines, restrictions, sanctions or termination. Failure of organizations to abide by the law and their own policies, procedures and bylaws may lead to years of litigation and costly appeals. Effective outcomes will depend on how well the organization meets these requirements.

BACKGROUND — Why is this such a difficult problem? Table 1 outlines a list of organizational and individual barriers that may impede resolution. One of the key barriers is organizational awareness of the frequency and intensity of disruptive events and its downstream consequences. Does the organization make a conscious attempt to survey or otherwise assess the status of staff relationships?

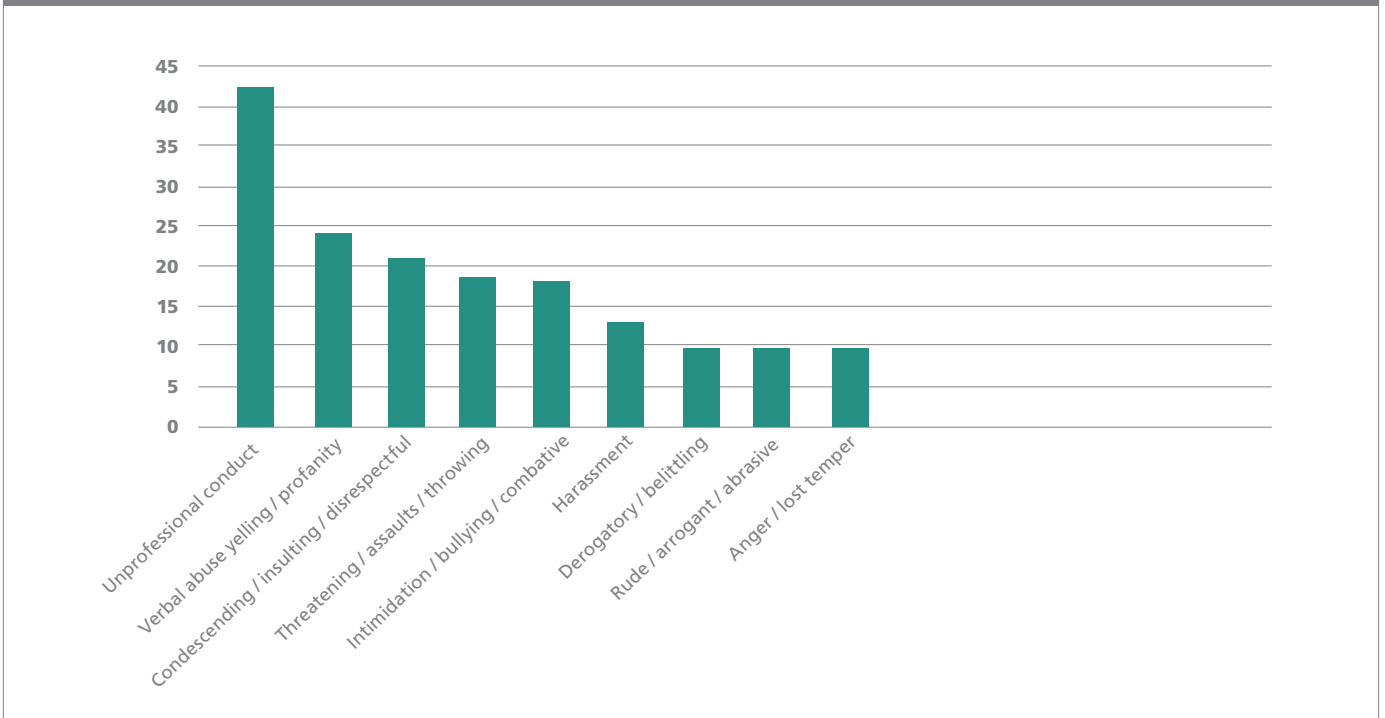
TABLE 1: BARRIERS

Organizational awareness
Organizational responsiveness (code of silence)
Reluctance to act (financial/ hierarchy)
Structure and process (policy/ reporting)
Process review (bias/ conflicts of interest)
Recommended action
Intervention (skill sets)
Physician liabilities (personality)



FIGURE 1

TYPES OF DISRUPTIVE BEHAVIORS



Next is the willingness of the organization to address the issue in a meaningful fashion. In many cases organizational reluctance can be traced back to:

- An ineffective organizational culture or leadership support.
- An underlying code of silence or fear of retaliation.
- A historical trend of tolerance and fear of crossing hierarchical boundaries.
- Fear of antagonizing a physician who brings patients and revenue into the organization.

Another potential barrier is structure and process. Issues related to policy and bylaws, inconsistencies or bias in incident reporting, review and evaluation, and ineffectual follow-up recommendations can seriously impair appropriate resolution.

The intervention process is probably the most crucial point in the process. Issues related to the skill sets and effectiveness of the individual or individuals doing the intervention, their recommendations for next steps on how best to address the incidents as well as possible underlying factors contributing to the behaviors is key to success.

Issues related to modifying physician attitudes and behaviors affected by such factors as age, culture, gender, training

FIGURE 2

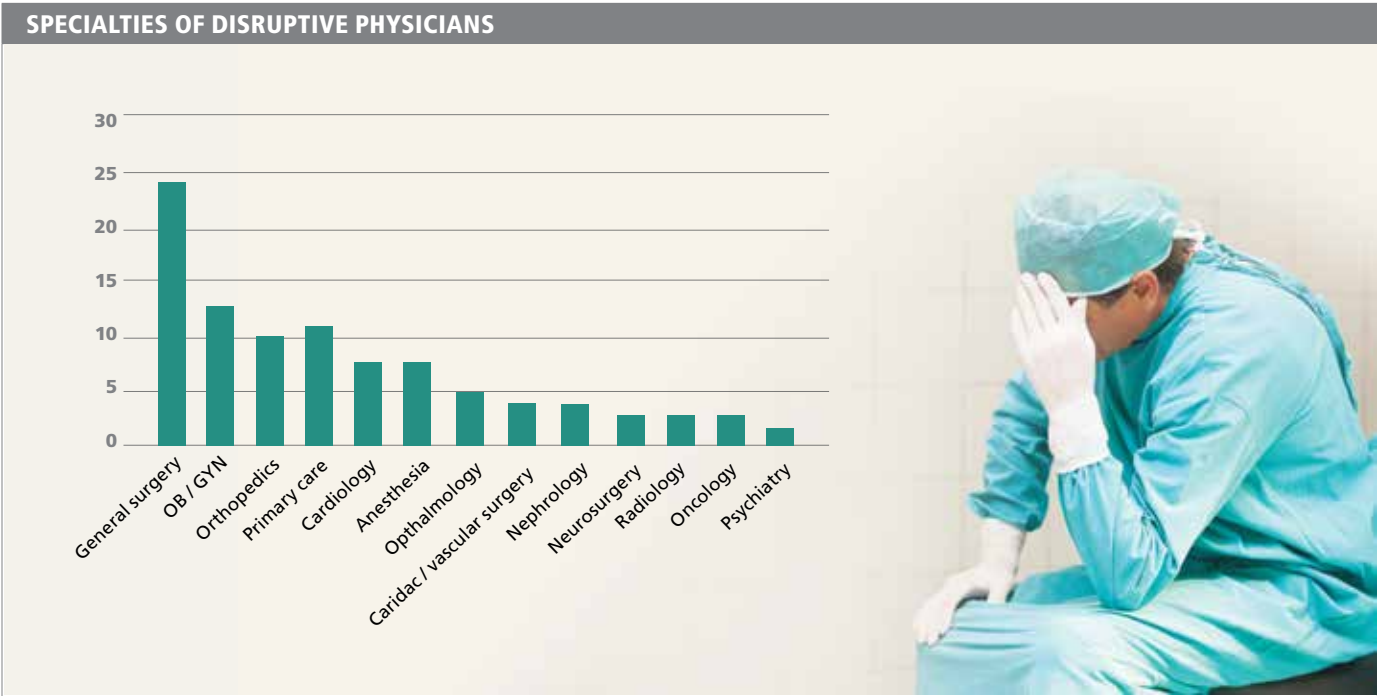


FIGURE 3



and other life experiences that mold their personality may also present a significant barrier to resolution. Process, recommendations, follow-through and ramifications for noncompliance need to be consistent with organizational policy and by-laws.

INVESTIGATION — Most disruptive behavior complaints are resolved without using the legal system but some of the more complicated cases can lead to legal proceedings. In an effort to assess the details of physician disruptive behaviors leading to court action we ran a sort on “physician” and “disruptive behavior” in the Westlaw computerized legal research system database.⁸

Our search yielded 205 cases in the “All Federal” database and 143 cases in the “All States” database. These cases were reviewed in regard to the documentation of disruptive behavior as the cause for action, the types of behaviors that were reported, the specialties involved, and the outcome of the legal proceedings.

Of the 205 federal cases, 145 were excluded from further analysis because they were not relevant. Forty-eight of the 60 remaining federal cases contained sufficient documentation of physician disruptive behavior. Of the 143 state cases, 29 were excluded from further analysis as irrelevant. Fifty-six of the remaining 114 cases contained sufficient documentation of physician disruptive behavior.

RESULTS — Figure 1 presents a graphic of the most common types of disruptive behaviors reported in the cases reviewed. Many of the cases had multiple behaviors listed and this graphic represents the aggregate amount of all disruptive behaviors mentioned.

Disruptive physician behaviors can take many forms. Most behaviors relate to unprofessional, abusive, condescending, belittling, harassing, and intimidating types of behaviors, with an infrequent occurrence of physical abuse. These types of disruptive behaviors are similar to the types of behaviors we have reported on previously in multiple different specialty journals.⁹⁻¹⁴

Figure 2 lists the types of specialists who were identified as being disruptive physicians. Obviously there is a higher incidence in what might be construed as “high-stress” specialties. There were other specialties mentioned at least once including neurology, urology, bariatric surgery, trauma surgery, plastic surgery, podiatry, neonatology, pediatrics, and doctors of osteopathic medicine. These specialties are similar to the specialties noted in our previous publications.⁹⁻¹⁴

Figure 3 lists the most frequent reasons for appeal. As with disruptive behaviors, most of the cases had multiple reasons given as the basis for appeal and the graphic represents the aggregate amount of all reasons given. Cited most frequently as the basis of appeal was a failure to follow due process.

The two key issues were whether the hospital followed its bylaws and challenges to protection under the Health Care Quality Improvement Act (HCQIA), which grants hospitals immunity for conducting peer review proceedings. Allegations of breach of contract, intentional malice and conspiracy were the next most common themes. Issues involving antitrust and

tortious interference were the next most common theme. Complaints of discrimination, retaliation, harassment and defamation of character were the next most common themes.

DISRUPTIVE PHYSICIAN BEHAVIORS CAN TAKE MANY FORMS.

Overall, the key principles for appeal revolved around inconsistencies or unfairness in process or proceedings, discrimination, retaliation or intention to harm. The desired outcome is either removal of sanctions or monetary rewards for lost wages, restraint of trade or emotional harm. In aggregate, the organization had a successful verdict in 77 percent of the cases.

DISCUSSION — The information on reasons for appeal and the results of court proceedings provide a new area for analysis. In more complex contentious cases the organization must recognize that a physician who is being singled out for disruptive behaviors will, under legal advisement, look to deflect blame or outline reasons as to why the process is flawed.

To be fair, there are cases where the physician has raised valid concerns as to justification of complaints, organizational intent, process fairness and consistency and recommended course of action. The issue is what steps the organization needs to take in order to prepare for the potential of litigation.

As a starting point it is crucial for the organization to have developed a code of conduct policy that sets the expectations for professional behaviors, defines disruptive behaviors and outlines the process and ramifications for noncompliance. Many organizations have the physicians sign an agreement to abide by this policy at the time of granting staff privileges or recredentialing. Most hospitals successfully defending against litigation were those having and following clearly defined policies and procedures.

Situations involving issues surrounding quality of care and physician skill may be related more to competency issues and must be handled accordingly. Educational efforts should be taken to inform staff and providers of what constitutes disruptive physician behavior, how it affects patient care and the importance of addressing these issues and taking action in a timely and appropriate manner. Educators, including risk managers, could use examples from these cases to help illustrate their points.

The next step is taking action. Interestingly, many of reported disruptive behaviors are the types of behavior that peers frequently excuse — raised voices, berating another in front of peers, condescension and insults. These may not be typically viewed as disruptive behaviors. On top of that is a hidden “code of silence” where observers of these types of behaviors don’t want to get involved.

The next steps include process, due diligence, compliance, consistency and documentation. In the federal cases the most

prevalent basis for appeal was discrimination (17/46); HCQIA issues (15/46) and antitrust (10/46). At the state level, the primary bases for legal action included antitrust (22/56); due process arguments (29/56) and breach of contract (29/56).

Some of the existing legal literature addresses the key issues. For example Zachary Erwin focuses on how courts should handle whistleblower cases by disruptive physicians.¹⁵ He analyzes case law, finding that most cases are disposed of in favor of the hospital. He discusses the three rationales most often applied by courts:

1. Qualified immunity under HCQIA.
2. Deference to hospital bylaws.
3. Sufficiency of documentation of disruptive behavior.

In his analysis of HCQIA applications, Paul Ho relies upon illustrative cases for his critique of HCQIA's failures and proposed alternatives to HCQIA.¹⁶ In another case study the authors examine the laws governing disruptive physicians in Wyoming, advocating that hospitals have their "house in order" before initiating action against a disruptive physician.¹⁷ If not, the accused physician may focus attention on any suggestion of a policy deviation or legal violation, drawing attention away from his or her disruptive behavior.

In regard to antitrust issues many physician complaints fail because the physician is unable to demonstrate an antitrust injury — an injury to competition — as opposed to an injury

to the physician as a competitor.¹⁸ As for cases where discrimination was alleged by the physician, the physician typically has difficulty demonstrating that race, gender, or religious beliefs motivated the termination or other action against the physician.¹⁹

CONCLUSION — The results of our review suggest that despite efforts to raise awareness and develop policies and procedures to reduce its occurrence, disruptive behaviors still occur and often lead to individual and organizational turmoil that may result in legal proceedings.²⁰ The primary goal of any disruptive behavior program should be to prevent or reduce the incidence and impact of disruptive events and, when they occur, hold individuals accountable for their actions.

At the cultural level this requires an organizational commitment and support for a zero-tolerance policy for disruptive behaviors as a key component to protect staff and support patient safety. At the structural and policy level, the organization needs to have a well-defined code of conduct policy, a consistent process for incident reporting, evaluation and follow-through, and a well-thought-out process for intervention and follow-up.

Setting standards, following due process and written documentation are key components necessary to ensure a successful outcome. Efforts should be made to lower the likelihood of a disruptive event by providing appropriate education and training programs, individual coaching or counseling or behavioral modification programs to assure emotional stability and compliance with behavioral standards.²¹⁻²³

When behaviors get to the point where blame and resistance take charge, this opens up the door for legal involvement and expert opinion. Table 2 highlights some of the key components to look for during case review. Policy content, process review, event analysis committee reports, recommended action, like-case action consistency, documentation, intervention and follow-up are all issues that frame the specifics about the disruptive event.

TABLE 2: COMPONENTS OF EXPERT REVIEW:
Review of policy and procedures: definitions, criteria, process, and potential ramifications
Review of complaints: severity/circumstances/frequency/history/trend
Review recommendations: appropriateness/consistency/alternative approaches
Review intervention process: documentation/timeliness/responsiveness/plan
Assess consistency with other similar types of issues/assess organizational culture
Assess overall physician reaction and responsiveness to recommendations

Addressing the seriousness of the disruptive behavior, compliance with existing policies and procedures, consistency and fairness in evaluation, intervention, recommendations, follow-through, and anticipation of the surrounding legal challenges will help guide those involved as the case progresses.

Education efforts may be necessary to inform staff and providers of what constitutes disruptive physician behavior and

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what consequences may evolve. The true intent of a disruptive behavior program is to raise organizational awareness as to what it is and what it can do, to educate, train, counsel, provide support for behavioral compliance, to hold individuals accountable for their actions and to provide the appropriate intervention when disruptive events occur.

When both sides can't agree, it sets the stage for legal involvement. Issues related to facts and interpretation, intent and objectivity, legitimacy, interference, due process, consistency, bias, and discrimination and harassment often cloud the situation.

Proactively recognizing up front the potential themes for appeal and addressing these issues through appropriate investigation, evaluation, intervention, recommendation and documentation will help provide an important trail for legal opinion.



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