

LAWYER OR PSYCHIATRIST? HANDLING “DISRUPTIVE” OR “IMPAIRED” PHYSICIAN CASES

Martha E. Brown, MD
Associate Dean of Faculty Development
Associate Professor of Psychiatry
USF College of Medicine

Michael R. Callahan
Partner
Katten Muchin Rosenman LLP
525 W. Monroe Street / Chicago, IL

Julian L. Rivera
Partner
Brown McCarroll, L.L.P.
111 Congress Ave / Austin, TX

Behavior/Impairment Issues From Different Perspectives

- I. Clinical Identification of the “Disruptive” or “Impaired” Physician
- II. General Legal Perspective – From the Perspectives of the Hospital Lawyer and the Physician Lawyer
- III. The Psychiatrist’s Clinical Approach
- IV. After Care Legal Issues

Colleagues and Contributors Of Dr. Brown's Material

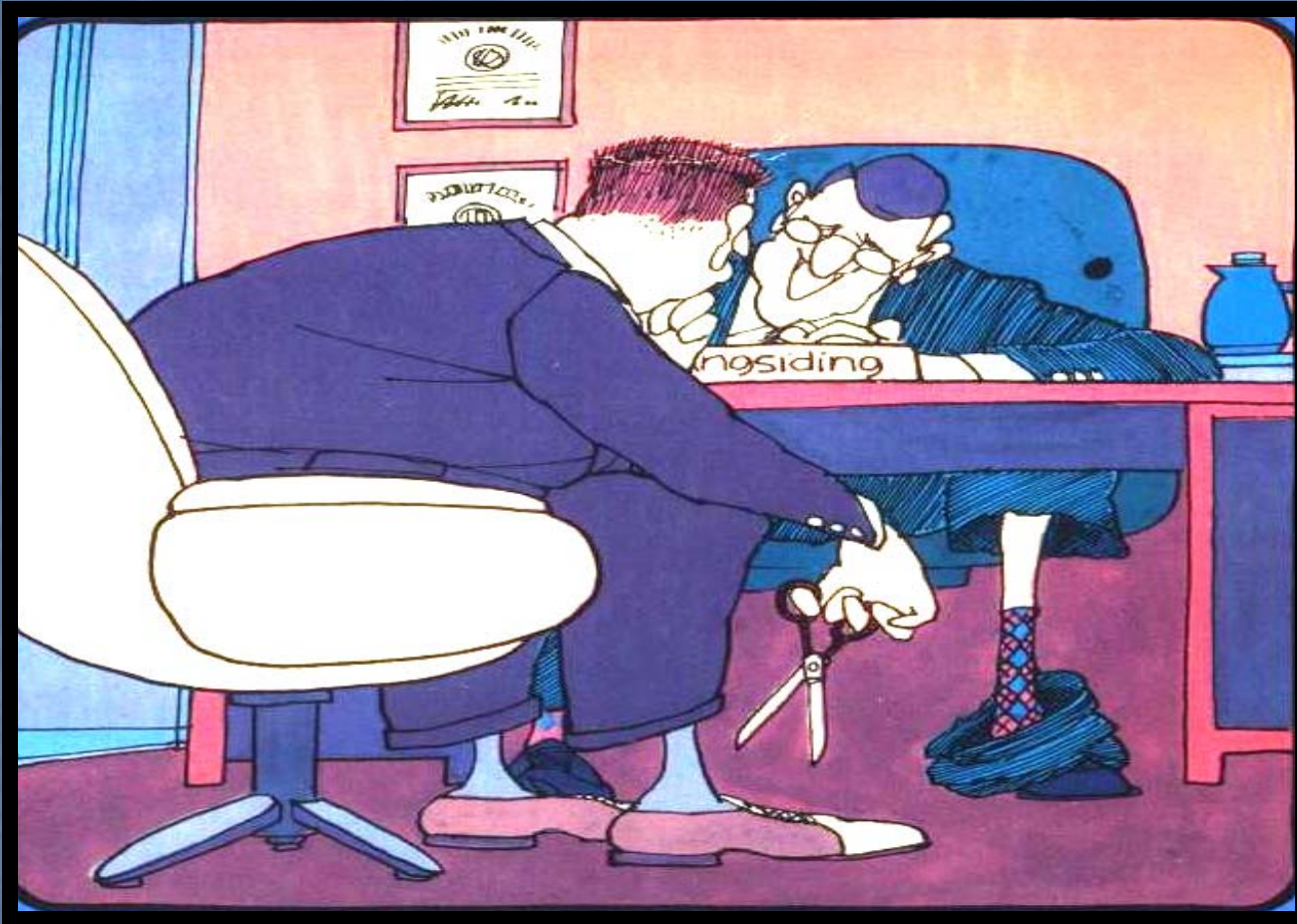
William Swiggart, MS, LPC/MHSP
Associate in Medicine
Co-Director
Vanderbilt Center for
Professional Health

Reid Finlayson, MD
Assistant Professor of Psychiatry
Director
Vanderbilt Comprehensive
Assessment Program

Betsy White Williams, Ph.D., M.P.H.
Rush University Medical School
Professional Renewal Center

Martha E. Brown, MD
Associate Dean of Faculty
Development
Associate Professor of Psychiatry
USF College of Medicine

When "a little chat" doesn't work



Mr. Bangsiding felt (and wrongly so) that a little chat would be enough to stop Bob's disruptive behavior

Why bother dealing with disruptive behavior?



Reported Prevalence

State/Country	Prevalence	Source
Alabama	12%	Referrals
Indiana	8%	Referrals
	1%	Statewide
Kentucky	20%	Referrals
	0.4%	Statewide
Tennessee	30%	Referrals
Wisconsin	30%	Referrals
Australia	36%	Referrals
England	6%	Disciplinary

Multiple References Available

Failure to Address Disruptive Conduct Leads To

- Team members may adopt disruptive person's negative mood/anger (Dimberg & Ohman, 1996)
- Lessened trust among team members can lead to lessened task performance **(always monitoring disruptive person)**... effects quality and pt safety (Lewicki & Bunker, 1995; Wageman, 2000)

Felps, W et al. 2006. How, when, and why bad apples spoil the barrel: negative group members and dysfunctional groups. *Research and Organizational Behavior*, Volume 27, 175-222.

Disruptive Behavior Leads to Communication Problems...Communication Problems Lead To Adverse Events¹

- Communication breakdown factored in OR errors 50% of the time²
- Communication mishaps were associated with 30% of adverse events in OBGYN³
- Communication failures contributed to 91% of adverse events involving residents⁴

Gerald B. Hickson, MD
James W. Pichert, PhD
Center for Patient & Professional Advocacy
Vanderbilt University School of Medicine

1. Dayton et al, J Qual & Patient Saf 2007; 33:34-44.

2. Gewande et al, Surgery 2003; 133: 614-621.

3. White et al, Obstet Gynecol 2005; 105(5 Pt1):1031-1038.

4. Lingard et al, Qual Saf Health Care 2004; 13: 330-334

Disruptive Behavior Creates

- fear
- confusion or uncertainty
- vengeance vs. those who oppose/oppress them
- hurt ego/pride
- grief (denial, anger, bargaining)
- apathy
- burnout
- unhealthy peer pressures
- ignorance (expectations, behav. standards, rules, protocols, chain of command, standards of care)
- distrust of leaders
- dropout: early retirement or relocation
- errors
- ***disruptive behavior begets disruptive behavior***

Spectrum of Disruptive Behaviors

Aggressive

Anger Outbursts
Profane/Disrespectful
Language
Throwing Objects
Demeaning Behavior
Physical Aggression
Sexual Comments or
Harassment
Racial/Ethnic Jokes

Passive Aggressive

Derogatory
comments about
institution,
hospital, group,
etc.
Refusing to do
tasks

Passive

Chronically late
Not responding
to call
Inappropriate or
inadequate chart
notes

Two systems interact

The external system

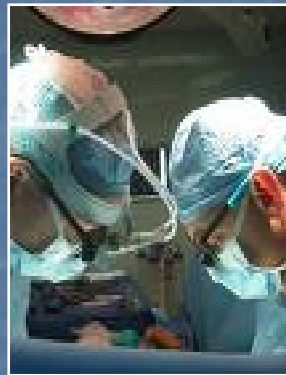
Functional &
nurturing



Hospital/Clinic



Physician



The internal system

Good skills



Dysfunctional

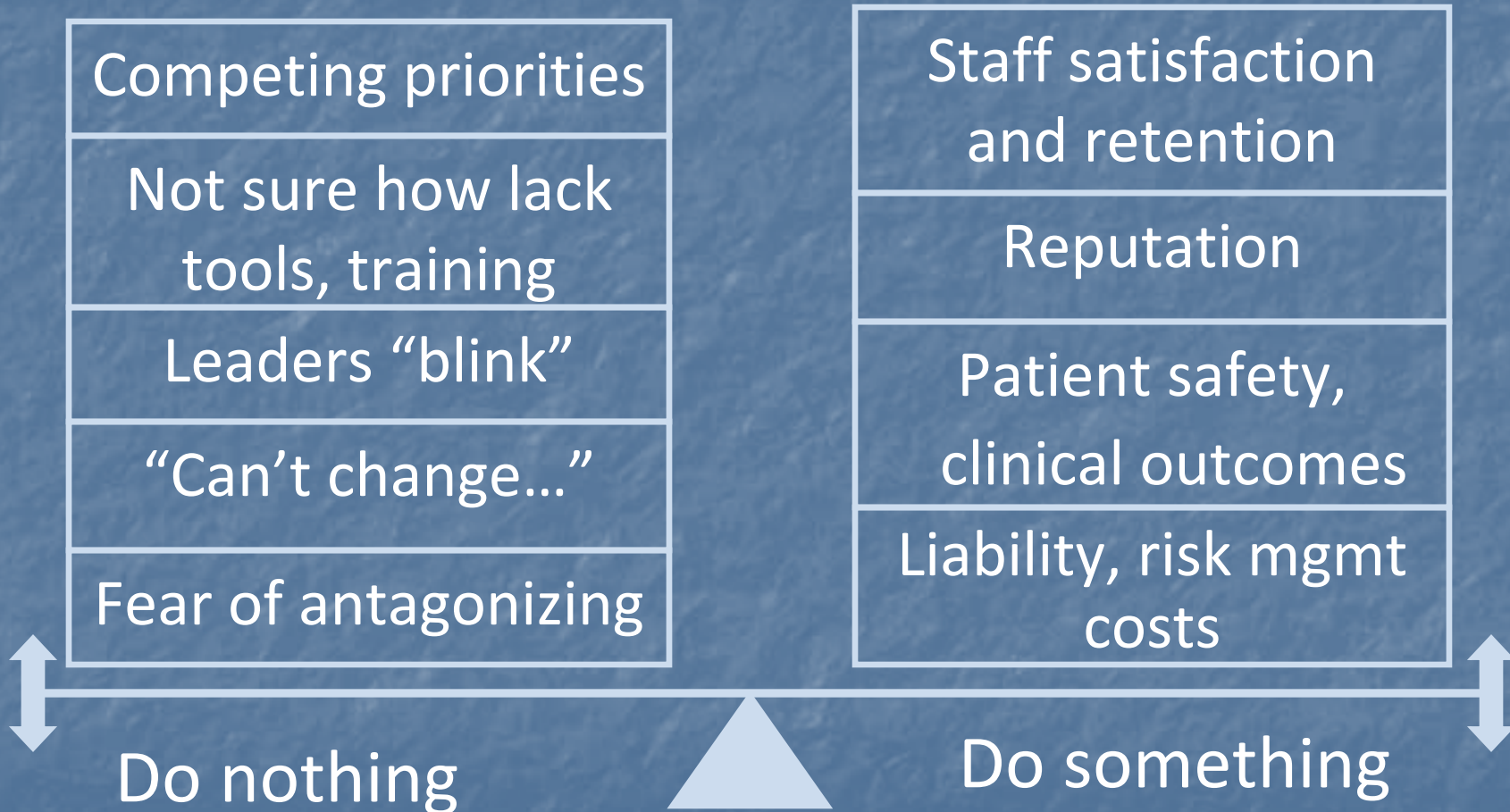
Poor skills

"The Perfect Storm"

Why are systems hesitant to act?



The Balance Beam



June 2009, Unprofessional Behavior in Healthcare Study, Studer Group and Vanderbilt Center for Patient and Professional Advocacy; Hickson GB, Pichert JW. Disclosure and Apology. National Patient Safety Foundation Stand Up for Patient Safety Resource Guide, 2008; Pichert JW, Hickson GB, Vincent C: “Communicating About Unexpected Outcomes and Errors.” In Carayon P (Ed.). Handbook of Human Factors and Ergonomics in Healthcare and Patient Safety, 2007

Why Might a Medical Professional Behave in Ways that are Disruptive?

1. Substance abuse and psychiatric issues
 - Alcohol and Drugs
 - Psychiatric Disorders including Major Depressive, Bipolar, & Anxiety Disorders
2. Narcissism, perfectionism or other personality traits/disorders
3. Spillover of family/home problems

Why Might a Medical Professional Behave in Ways that are Disruptive? (cont'd)

4. Poorly controlled anger/Snaps under heightened stress, perhaps due to:
 - a. Poor clinical/administrative/systems support
 - b. Poor mgmt skills, dept out of control
 - c. Back biters create poor practice environments
5. Well, it seems to work pretty well and the system reinforces the behavior
6. No one addressed it earlier (why? See #5)
7. Physical Illness

Why Might a Medical Professional Behave in Ways that are Disruptive? (cont'd)

8. Sexual Disorders including harassment and stalking
9. Prescription drug use (appropriate and non-appropriate)
10. Family of origin issues—guilt and shame
11. Training or poor social skills entering into medicine
12. May ignore feelings and problems
 - Often has burnout
 - May be unaware of their impact on others

Disruptive Behavior – Personal Systems



“More than 20% of caregivers have witnessed actual harm come to patients as a result of condescending, insulting or rude behavior by professionals.”

Nurses and Other Clinical Providers’ Concerns about Disrespect and Abuse

77% are concerned about disrespect they experience	This person is disrespectful or abusive toward them in at least a quarter of their interactions.	28%
	This behavior has gone on for a year or more	44%
7% have spoken with this peer and shared their full concerns	Correlation between the frequency of mistreatment and intent to quit their job.	R = .424 P < .001
	Correlation between the duration of abuse and intent to quit their job.	R = .190 P < .001

Source: Silence Kills 2005, VitalSmarts

What controls behavior?

Thomas Krause, PhD

Presentation at the National Patient Safety Foundation Board of Governors Meeting June, 2007

Consequences

- Consequences control behavior
- Antecedents influence behavior only to the extent that they predict consequences...
- Timing, consistency and significance of consequences affect their impact

Thomas Krause, PhD

Presentation at the National Patient Safety Foundation Board of Governors Meeting June, 2007

Consequences

- disharmony and poor morale¹
- staff turnover²
- incomplete and dysfunctional communication¹
- heightened financial risk and litigation³
- reduced self-esteem among staff¹
- reduced public image of hospital¹
- financial cost¹
- unhealthy and dysfunctional work environment¹
- potentially poor quality of care^{1,2,3}

1. Piper, 2000

2. Rosenstein, 2002

3. Hickson, 2002

Disruptive Behavior and Institutional Functioning

- Depending on the nature of the disruptive behavior it can engender:
 - Deviation from accepted institutional protocols and support staff providing services out-of-scope
- Disruptive behavior decreases staff's understanding of their role
 - A significant decrease in staff's reported understanding of their role and in staff's reported sense of affiliation
- The presence of the disruption ultimately results in breakdown of:
 - Communications; Affiliation; Roles; Protocols and duties

Legal Perspective

Legal issues to be addressed:

- Joint Commission and Bylaw Standards
- AMA Model Code of Conduct
- State reporting obligations
- National Practitioner Data Bank reporting
- Negligent credentialing/malpractice
- HR Employment
- Peer review/confidentiality
- Aftercare obligations and considerations
- Responding to third party inquiries

Joint Commission and Bylaw Standards

- Must determine health status of applicants and existing members of Medical Staff (MS.06.01.05, EPs 2 and 6)
 - Inquiry as part of appointment/reappointment process
 - Bylaws should contain provisions which provide:
 - Burden on physician to produce information regarding history of disruptive/impaired behavior
 - Failure to disclose requested information shall result in withdrawal of application from consideration
 - If information discovered after appointment/reappointment, physician can be terminated

Joint Commission and Bylaw Standards (cont'd)

- Obligation to monitor physician conduct/behavior
- Obligation of physician to cooperate
- Physicians should be obligated to disclose any impairment or actions taken at another hospital
- Disruptive behavior to be reported via incident report and assessed with direct involvement by physician and persons reporting the event
- "Reasonable suspicion" of impairment must be reported to Department Chair, CMO, VPMA, President of Medical Staff and CEO

Joint Commission and Bylaw Standards (cont'd)

- Definition of “professional behavior” and “disruptive behavior” tied to Code of Conduct or Disruptive Behavior Policy to be included in Bylaws or cross referenced to Policies
- Bylaws should make clear that overall goal of policy is to work collaboratively with the MD to identify issue source and develop plan to help MD achieve compliance
- Corrective action should be last option after other measures have failed unless action needed immediately to protect patients, employees and general public

Joint Commission and Bylaw Standards (cont'd)

- Joint Commission accredited hospitals must have adopted a Disruptive Behavior Policy by January, 2009 for all hospital personnel – not just physicians
 - Some hospitals have adopted a Code of Conduct applicable to physicians, a Disruptive Behavior Policy applicable to all, a Physician Wellness Committee, an HR Policy applicable to employed physicians as well as a standard for recommending corrective action
- A review of these different policies often times reveals conflicting definitions of “unprofessional” or “disruptive behavior” or “impaired conduct”

Joint Commission and Bylaw Standards (cont'd)

- All affected individuals should be treated in same manner irrespective of whether they are independent or employed – easier said than done
- Application of different behavior standards and consequences standards may result in legal challenge from physicians/employees as well as different standards of patient care if independent physicians are given more latitude than employed physicians – corporate negligence issues if harm to patients results from inaction

American Medical Association

Model Code of Conduct

- Protect accused physician's right to fair process
- Caution against discipline for good faith criticism of hospital or economic competition
- "Appropriate Behavior": Reasonable conduct to advocate for patients, engage in professional practice or participate in hospital operations or medical staff leadership
- "Inappropriate Behavior": Unwarranted conduct that is reasonably interpreted as demeaning or offensive – only "disruptive" if persistent
- "Disruptive Behavior": Abusive conduct including sexual or other forms of harassment or intimidation to extent quality of care or patient safety could be compromised

AMA

Model Code of Conduct (cont'd)

- Begin with tiered, non-adversarial interventions
- Complaints should be written and well-documented
 - Facts
 - Witnesses
 - Consequences, if any, to patient care or safety
- Copy of complaint to accused physician
- Retaliation policy
- Escalating Medical Staff action – “final warning” letter before corrective action with due process
- Expungement from physician’s file after two years if no related action is taken

Data Bank and State Reporting Requirements

- Remedial measures taken with respect to disruptive/impaired behavior are not reportable to Data Bank and usually not to the state unless:
 - Action involves involuntary termination, suspension or reduction of privileges resignation while under investigation or in lieu of reportable corrective action, or a mandatory consultation requiring prior approval and
 - Conduct has or may have an adverse impact on patients.
- Leaves of absence, voluntary reduction of temporary privileges, monitoring, proctoring, mandatory consultations not requiring prior approval are not reportable – but may have impact on physician licensure

Data Bank and State Reporting Requirements (cont'd)

- A physician under any of these remedial measures who returns with the ability to exercise full privileges is not reportable even if determined to be impaired
- If, however, privileges are terminated or reduced or suspended after the leave or because physician refused to cooperate or participate or did not comply with remedial action plan, decisions are reportable to Data Bank
 - Must decide if physician does or does not receive a hearing as part of the after care or well-being if terminated plan

Data Bank and State Reporting Requirements (cont'd)

- If no hearing, but is reported, hospital and medical staff cannot access HCQIA immunity protections provisions
- A better alternative would be to provide at least some form of hearing – limited scope- physician may simply resign
- Must check state laws on reportability
 - In Illinois, any determination that impairment exists must be reported even if physician successfully participates in plan and privileges are maintained or restored
 - This difference on how a state versus the Data Bank handles reporting can sometimes complicate effort to get the physician to willingly participate in a plan

Negligent Credentialing and Malpractice Issues

- Hospital has legal duty to make sure that physician is currently competent to exercise each of the clinical privileges given them. If hospital/medical staff knew or should have known that MD's behavior or conduct presented a risk to patients and no appropriate remedial measures were taken, a hospital can be held independently liable in the event that a patient is injured as a result of MD's conduct.
 - Disruptive behavior can cause break down in communication, interfere with timely delivery of care and cause some caregivers to treat the patients of the disruptive physician differently. Injuries resulting from such conduct may expose hospital to negligence claim.
 - As per studies of Dr. Hickson, disruptive physicians can give rise to higher incidence of malpractice

Confidentiality Issues

- Need to make sure that all necessary steps are taken to maximize protection of disruptive/impaired physician minutes, reports, analyses, etc. under state peer review confidentiality statutes/PSO protections
- Patient Safety Organization (“PSO”) complications:
 - If hospital is participating in a PSO and is collecting peer review information as part of its Patient Safety Evaluation System, such information is strictly privileged and confidential and not subject to discovery or admissibility in state and/or federal proceedings – with exceptions

HR Employment Issues

- Compare “disruptive behavior” and “impaired physician” standards as applied to employed physicians and other hospital employees to those applied to medical staff members
- Fairly common to see employed physicians held to a higher or different standard than independent physicians
- Process for dealing with disruptive behavior of employed physician also can be different and remedial measures can be imposed with less process and terminations imposed more quickly

HR Employment Issues (cont'd)

- Failure to report gives rise to possible liability claims depending on how hospital responds to third party requests regarding physician's behavior/impairment
- If physician is reported but without first receiving a hearing, then hospital cannot seek HCQIA protections

How Can Psychiatrists Approach Disruptive Behavior??

- One model - **Fitness For Duty**
- Defined as whether the individual can perform the job duties of their particular job with reasonable skill and safety
- Individuals are expected to report to work in a fit and safe condition
- Difficult issues include “functioning alcoholics,” the job is the last thing to go, denial, lying, and impairments not readily identified on the job

PSYCHIATRIST'S WORK LIST

- Talk with referral source about what policies they have in place
- Ask what hospital or medical group is willing to do about the problem
- Seek information from collateral sources
- Assess the level of the problem and where to start
 - Inpatient evaluation
 - Outpatient evaluation
 - 360 workplace evaluation

STARTING AT THE TOP

- Start with a comprehensive outpatient evaluation with psychological testing
- Many outpatient evaluations SHOULD lead to a five to seven day inpatient evaluation
- Determine what category the professional falls within:
 - Needs long-term inpatient treatment and has a treatable disorder or an Axis II Disorder
 - Determine can do well outpatient, can keep working, needs information, therapy, monitoring, and/or CME
 - Needs to find a paper hat job

Comprehensive Evaluation

- Guidelines for Fitness for Duty Evaluations
- Multidisciplinary: 1-5 days
 - Medical
 - Psychiatric evaluation
 - Psychological testing
 - Psychosocial including genogram
 - Addiction screening
 - Collateral information
- Comprehensive report with recommendations

Assessments Are Necessary

- A comprehensive assessment will hopefully determine whether the professional has a problem, the extent of the problem, and the type of treatment that may be effective
- However, there are malicious complaints
- Not all assessments are definitive
- Not all impairments are proven
- Not all psychiatrists are created sane

Case Presentation

Dr. X is a 40 year old general surgeon referred for evaluation following several angry outbursts in his hospital's OR. The most egregious (and final) outburst involved his threatening to shoot one of his OR staff. Although he reportedly immediately told staff that he wasn't serious about the threat, a complaint was filed because he was commonly known to have an extensive gun collection at his home, and this staff member lived in the same neighborhood.

Clinical Approaches To The Disruptive Professional

This Is Treatable But Sometimes Hard to Deal With

- When the professional who is taking a CME course on the issue, cusses out and files complaints against your assistant and the CME office
- When the professional punches a hole in your wall
- When the professional is arrested for hiring people to injure and kill those who have made them mad

The Solution Many Consider

- Could be the most cost saving
- Certainly efficient
- Saves time
- Simple
- Great fantasy
- However, not real practical...



DETERMINING THE APPROACH

- Does the organization want to monitor disruption?
- What legal support is there?
- What is the tolerance level of the staff for dealing with the behavior and do they need additional training?
- Determine if you can accept delayed gratification



Institutional Barriers To Dealing With The Problem

- Behaviors not extensively documented
- Hospitals do not want to “anger” their top producers
- Lack of in-depth policies in the hospital or practice
- No one likes lawyers

Infrastructure for Addressing Unprofessional Behavior

- Leadership commitment
- Model to guide graduated interventions
- Supportive institutional policies
- Surveillance tools to capture pt/staff allegations
- Processes for reviewing allegations
- Multi-level professional/leader training
- Resources to help disruptive colleagues
- Resources to help disrupted staff and patients

Hickson GB, Pichert JW, Webb LE, Gabbe SG. A Complementary Approach to Promoting Professionalism: Identifying, Measuring and Addressing Unprofessional Behaviors. *Academic Medicine*. November, 2007.

Treatment

- Professionals have specialized issues and dynamics, usually requiring specialized treatment
- Accurate diagnosis and appropriate treatment is essential
- Monitoring by a professional program greatly improves the success rate
- Treatment works!

Treatment Types

- Outpatient and/or inpatient treatment
- CME Courses
- Medication management
- Psychological testing
- Restriction on type of practice
- Psychotherapy
- Workplace monitoring

Characteristics and Behavioral Change in the First 39 Disruptive Physicians

Samenow CP, Swiggart W, Blackford J, Fishel T, Dodd D, Neufeld R, Spickard A. A CME Course Aimed at Addressing Disruptive Behavior. Physician Executive; 34 (1) Jan/Feb 2008: 32-40.

www.mc.vanderbilt.edu/root/vumc.php?site=cph
www.cme.hsc.usf.edu/distressed_physician/

General Trends

- At 3 months, significant improvements in 20 of the 22 physicians
 - Increased motivating behaviors and motivating impact
 - Decreased disruptive behaviors and disruptive impact
- Changes in behavior reported by “others”

Samenow CP, Swiggart W, Blackford J, Fishel T, Dodd D, Neufeld R, Spickard A. A CME Course Aimed at Addressing Disruptive Behavior. Physician Executive; 34 (1) Jan/Feb 2008: 32-40.

Demographics

- Total Physicians Studied = 39
- Mean Age: 49.7 (compare to CPH mean age 49)
- Age Range: 27 - 64
- Predominantly Male (84%) and Caucasian (87%)
- 49% Married, 10% Divorced, 26% Multiple, 10% Single
- Group Practice/Partnership (41%), Hospital Based (21%), Solo (10%), Trainee (3%)

Samenow CP, Swiggart W, Blackford J, Fishel T, Dodd D, Neufeld R, Spickard A. A CME Course Aimed at Addressing Disruptive Behavior. Physician Executive; 34 (1) Jan/Feb 2008: 32-40.

Specialty Types

Specialty Medicine	7 (18%)
Anesthesia	5 (13%)
General Med/Family Practice	5 (13%)
Specialty Surgery	5 (13%)
Ob/Gyn	5 (13%)
General Surgery	4 (10%)
Emergency Med	2 (5%)
Dentist	1 (3%)
Other	5 (13%)

Samenow CP, Swiggart W, Blackford J, Fishel T, Dodd D, Neufeld R, Spickard A. A CME Course Aimed at Addressing Disruptive Behavior. Physician Executive; 34 (1) Jan/Feb 2008: 32-40.

WHAT WE HAVE LEARNED

- Medical student and resident training cultivates many of the disruptive behaviors as they learn from their mentor's behavior
- Information needs to be widely distributed to hospitals and medical practices that this is treatable, saves money, prevents malpractice suits, and that early intervention is best

WHAT WE HAVE LEARNED

- There is a need to develop standard, model policies for hospitals
- Monitoring contracts need to be flexible
- 360 evaluations are imperative for monitoring and to see how the professional is progressing
- Not all can be helped or saved
- Intensive small group CME with monitoring works for many

After Care Legal Issues

- Disruptive behavior, impairment or not, oftentimes results in participation in educational/rehab program to maintain privileges
- Terms of program can be dictated by Physician Health Program and/or hospital through Physician Wellness Committee
- Proof of compliance is important to the physician
- Hospital should monitor compliance with agreement – strict incident reporting
- Continued membership and privileges should be contingent on continued compliance – consider monitoring or concurrent review of cases

After Care Legal Issues (cont'd)

- If violation of plan does not trigger removal from staff then hospital should document why not and what additional remedial measures will be imposed to effectuate compliance
- Informal resolution vs. full due process
- Termination/suspension for violation of program would be reportable to Data Bank and probably to the state
- Must also decide if violation will result in automatic termination with or without a hearing for HCQIA protections

Responses to Third Party Inquiries

- Hospital may receive third party inquiry about physician as part of another appointment, reappointment or employment decision by another facility
- Different hospital responses:
 - MD resigned before disruptive or impaired behavior is confirmed
 - MD resigned in middle of investigation
 - MD resigned after findings confirmed
 - MD terminated for failure to comply with after care plan
 - MD is successfully complying with program
- Proactive effort by physician to document compliance or decision to leave

Responses to Third Party Inquiries

- No duty to respond to any third party inquiry Kadlec Medical Center v. Lakeview Anesthesia Associates (527 F.2d 412 (5th Cir. 2008) (Circuit Court of Appeals overturned District Court decision that such a duty existed in light of knowledge of hospital and group that employed physician was impaired on Demerol because Louisiana law did not impose such a duty)

Responses to Third Party Inquiries (cont'd)

- Although no duty to respond, if one is provided, hospital cannot purposefully nor negligently misrepresent the circumstances of physician's status or mislead the third party
- Hospital may consider having physician sign separate waiver of liability form
- Coordination with physician may avoid later conflict

Responses to Third Party Inquiries (cont'd)

- Hospital may consider having physician sign absolute waiver form
 - Use of such form commented on favorably in recent 7th Circuit opinion. Botvinick v. Rush University Medical Center (574 F.3d 414 (7th Cir. 2009))
 - If absolute waiver is viewed as unenforceable, may be able to rely on existing state peer review immunities

Responses to Third Party Inquiries (cont'd)

- Hospital may argue that response to a third party is privileged peer review communication and if sued by the physician, response may be deemed inadmissible (Soni v. Elmhurst Memorial Hospital)
 - Hospitals may also have an immunity clause in Medical Staff Bylaws for peer review decisions and communications
- Physician may argue violations of federal and state disability and tort laws

Summary

- Disruptive behavior is a patient safety issue
- State PHPs can be an extremely valuable resource for both physicians and institutions
- An objective, comprehensive assessment is invaluable
- It is important to understand the systems issues related to an individual's behavior