Managing Problem Practitioners: A Leadership Guide to Dealing With Impaired, Disruptive, Aging, and Burned-Out Clinicians is the medical staff’s answer for developing policies and procedures that address physician impairment, disruptive behavior, and problems associated with aging. Expert Todd Sagin, MD, JD, provides the guidance the medical staff services department needs to develop and implement a process for assessing and resolving legally compromising situations. Don’t get caught unprepared—reduce your lawsuit risk and keep your patients and clinicians out of harm’s way.

This book will help you:

- Develop an aging physician policy that protects physicians and the organization
- Train medical staff leaders on how to deal with a disruptive physician
- Take the proper steps when physicians fail to correct their behavior
- Design a physician wellness committee that is supportive of the medical staff
- Set and communicate clear expectations of physician behavior and competency

Meet the author: Todd Sagin, MD, JD, is a physician executive recognized across the nation for his work with hospital boards, medical staffs, and physician organizations. He is the national medical director of Sagin Healthcare Consulting, LLC, and HG Healthcare Consultants, LLC, which provide guidance on a wide range of healthcare issues. He served for over half a decade as the vice president and national medical director of The Greeley Company, Inc., in Danvers, Massachusetts.
MANAGING PROBLEM PRACTITIONERS
A Leadership Guide to Dealing With Impaired, Disruptive, Aging, and Burned Out Clinicians

Todd Sagin, MD, JD
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About the Author

Todd Sagin, MD, JD, is a physician executive recognized across the nation for his work with hospital boards, medical staffs, and physician organizations. He is the national medical director of Sagin Healthcare Consulting, LLC, and HG Healthcare Consultants, LLC, which provide guidance on a wide range of healthcare issues. He served for more than half a decade as the vice president and national medical director of The Greeley Company, Inc. Dr. Sagin is a practicing family physician and geriatrician who has held executive positions in academic and community hospitals and in organized medicine. He frequently lectures and facilitates retreats on medical staff affairs, physician leadership skills, relationships between hospital and doctors, strategic healthcare planning, governance, and related topics.
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Introduction

The clinical practitioner is the linchpin in healthcare services and the most critical element in the performance of good medical care. For this reason, healthcare practitioners are given great respect and generally granted immense latitude to carry out the responsibilities of their profession. Individual practitioners are typically held in high regard by their patients and the public, and their actions impact the lives and livelihoods of everyone.

In 2015, there are nearly one million licensed physicians in the United States and many more advanced practice nurses, physician assistants, dentists, podiatrists, and other clinical practitioners. It is not surprising that in a cohort of this size, there are individuals whose performance is found wanting and in need of intervention. This book is meant to assist those who undertake these interventions.

Problematic practitioners fall into two broad categories. The first are those whose clinical competence is deficient. This may result from an inadequate knowledge base, weak procedural skills, poor clinical reasoning, or inadequate clinical judgment. There are many available tools to identify and address such clinical deficiencies, and for the most part they will not be addressed in this book. The second category of problematic practitioners includes those who regularly engage in behaviors considered unprofessional or disruptive; those who are too burned out to engage in medicine with the requisite concentration, energy, and commitment; and those with substance abuse or other health issues (including those commonly associated with aging) that impair their ability to practice medicine safely. It is this latter category of practitioners who will be discussed in the pages that follow.

The world of healthcare in the second decade of this century is undergoing seismic change that is bringing new focus on issues of quality, safety, and cost. In the United States, we spend considerably more for healthcare services than anywhere else in the world, yet we lag in many quality and safety metrics. In addition, during the last century, our healthcare institutions have focused on efficiency for providers but have become less and less responsive to the needs and wishes of patients. As a result, patients and their families, payers,
Introduction

politicians, and employers are all putting immense pressure on healthcare organizations and their leaders to improve the quality and safety of care, reduce cost, and ensure more patient-centered care. Healthcare leaders are, in turn, looking more closely at practitioners to make sure they can deliver in these important dimensions. Where performance suffers because of impaired practitioner health or unprofessional conduct, such leaders are expected to intervene and resolve the attendant concerns.

Managing troubled colleagues does not come easy to physicians and other healthcare leaders. It has been widely known for years that intimidating and demeaning behaviors are a serious problem. Verbal outbursts, condescending attitudes, refusing to take part in assigned duties, and physical threats all create breakdowns in the teamwork, communication, and collaboration necessary to deliver patient care. Failure to address poor practitioner performance for any reason can lead to patient injury, citations from accrediting agencies, corporate negligence lawsuits from patients and their families, legal charges from federal and state governments, and serious harm to a medical group or hospital’s reputation. The problem of disruptive doctors has come out of the shadows and forced healthcare leaders to take definitive steps to rein in unprofessional conduct.

However, interventions to address the myriad of problem practitioners are fraught with difficulty. The growing evidence demonstrating how impaired and unprofessional practitioners undermine both patient safety and efforts to improve the quality of care has provided new impetus for leaders to address the performance of these colleagues. Furthermore, it has become increasingly difficult to justify why behaviors that are not tolerated in other sectors of society should be allowed to persist when evidenced by physicians and other clinical practitioners. But most healthcare leaders are not trained to identify practitioner impairment or recognize struggling colleagues. When these leaders do become aware of the need for intervention, they are often poorly prepared for the undertaking. Training to manage the difficult conversations and decisions that must be made is lacking in the backgrounds of most healthcare professionals. Interventions carried out poorly often result in a host of serious troubles for the various parties involved.

Taking action to address problem practitioners can trigger a web of legal regulations and statutes that can lead to liability for a healthcare institution. Indeed, successfully addressing the concerns raised by unprofessional or impaired practitioners typically involves negotiating a legal minefield. Practitioners subjected to disciplinary or corrective action frequently bring their own lawsuits against medical staffs and hospitals. Furthermore, there can be political repercussions within medical communities when interventions with problem practitioners lead to a loss of their clinical privileges or even licensure. In these cases, fellow practitioners often rally reactively around an impaired or unprofessional colleague. Trust and working relationships between practitioners and healthcare leaders in an organization can be sorely tested under these circumstances.
This book is written for healthcare leaders who must address the challenge of problematic practitioners. As a general rule, the book will talk about problematic physicians, since they can be the most difficult practitioners to address and their positions of relative power in health systems make their unprofessional conduct and impaired conditions more consequential. However, the assessments and tactics applied to physicians in these pages are generally applicable to a full range of clinicians. Furthermore, this focus on physicians is not to suggest that problems of impairment, burnout, and unprofessional conduct are not present in the larger multitude of healthcare workers, from nurses to medical technicians. Disruptive behavior, for example, has been documented to occur with regularity among nurses and pharmacists\(^1\) and workers in radiology and in the hospital laboratory.\(^2\) Also, practitioners with conduct problems are also not limited to hospital settings. They can be members of group practices, work in health centers and clinics, or be employed by nursing homes or rehabilitation centers. In this book, we will frequently talk about managing problem practitioners in the hospital setting and in the context of an organized medical staff, but the principles for intervention are generally applicable across a range of healthcare settings and can be utilized by healthcare organizations across the continuum of care.

In a similar fashion, this book will most often discuss the means by which physician leaders can manage the unprofessional conduct of colleagues. However, the principles and mechanics of intervention enumerated in this book can be applied as well by a range of healthcare leaders, including board members, members of a hospital executive team, group practice leaders, nursing directors, and so forth. In the end, the identification of problem behaviors and the approaches necessary to address them are largely generic, even though this book focuses on their application to physicians and those practitioners holding hospital privileges.

References


Disclaimer

The sample policies and documents found within this book are intended as a resource to healthcare organizations and are not intended to be utilized unmodified. They are meant to serve as examples that can be customized for the unique needs of a particular organization. Because laws and regulations differ across the 50 states and accreditation standards are constantly evolving, unmodified use of these documents cannot ensure compliance with applicable laws, regulations, or standards. In applying advice provided in this book, readers should consult legal counsel where appropriate to ensure the applicability of that advice in any particular circumstances.
Section I:
Addressing Practitioners Who Engage in Unprofessional Conduct
Chapter 1

The Parameters of the Problem

Professionalism: We Know It When We See It

Unprofessional conduct is widespread in hospitals and healthcare settings across America. Such behavior is certainly not a new phenomenon, and efforts to address it go back to antiquity. Historic efforts to codify professional behavior have been found in all cultures back to the very foundations of civilization. Some of the best-known codes in the western world are the Oath of the Prayer of Maimonides and the familiar Oath of Hippocrates.\textsuperscript{1} Abraham Flexner, charged with evaluating the quality of medical schools in the early 20\textsuperscript{th} century, issued his famous report in 1910 that deplored the vast majority of such institutions whose poorly trained graduates did not exemplify professionalism. In his report, he observes, “The medical profession has become diluted with practitioners of low ideals and professional honor.”\textsuperscript{2}

While sociologists study professionalism as a complex construct that conveys social power on particular groups, most physicians think of professionalism as a collection of attributes “...that we admire in our colleagues and strive for in ourselves.”\textsuperscript{3} It is how we like to portray ourselves to the public and set the most basic ground rules for acceptable behavior. “To profess, from the Latin \textit{pro-fateri}, means to speak forth or ‘to declare aloud or publicly.’ A profession, then, is a group of individuals speaking, out, together, to declare and make public the shared values and standards that govern their work ... Professional actions are those that are in conformance with the shared and declared standards and values of the group.”\textsuperscript{4}
Professional codes of conduct are known to change over time. This can be unsettling for physicians who had basic professional maxims drilled into them during their early training. For example, many historic medical codes emphasize a responsibility to put the needs of the patient first and foremost without compromise. However, in the 21st century, most medical professional societies recognize a professional obligation to consider the rights of other patients to care when deciding what resources to expend on an individual patient. For example, the Charter on Medical Professionalism, adopted by the American Board of Internal Medicine (ABIM) and others, enumerates as a fundamental principle a “commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide healthcare that is based on the wise and cost effective management of limited resources.”

Physicians advocating for the needs of their patients and health system leaders trying to allocate finite resources may clash, while they both believe they are upholding their commitments as professionals.

Another recent change in professional codes has been driven by the increasingly complex nature of medical care that usually involves the collaboration of multiple caregivers and often the participation of multiple experts. In the past, with the practice of medicine a more solitary venture, professional codes did not need to address issues of collaboration and interaction. Modern expressions of professionalism typically encompass a requirement to work well with others. Citing again the ABIM Charter on Medical Professionalism: “As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the process of self-regulation, including remediation and discipline of members who have failed to meet professional standards.”

Even as our medical societies revise and reach consensus on professional codes, practitioners struggle to live up to these standards. A national survey of physicians in 2007 found that 90% or more of the respondents agreed with the basic principles stated in the ABIM Charter on Professionalism. However, when asked about specific behaviors that would comport with these principles, the researchers found that the actions of a large percentage of physicians did not conform to the professional norms they espoused.

In this book, we stress the importance for healthcare organizations to be explicit about the professional duties they value and will enforce. The rapid changes buffeting the field of medicine are causing many to rethink, revise, and refine professional duties and priorities. This kind of change is healthy, but, it can generate confusion and discord when enforcement of professional standards becomes necessary. In the context of any particular medical community, it is not constructive for each practitioner to adhere to a personally selected definition of professionalism. Healthcare organizations should declare their adopted professional standards clearly in policies and in the orientation, education, and training of their practitioners.
What Constitutes “Unprofessional Conduct” or “Disruptive Behavior”? 

**Surgeon Arrested After Throwing Fit**

Oakland, CA, March 26, 2006 — The chief of neurosurgery at a hospital in Oakland, California was wrestled to the floor by sheriff’s deputies outside the operating room after he threw a tantrum because he had to wait for instruments to be sterilized after they had been obtained from another hospital. According to the neurosurgeon, a trauma patient needed immediate attention and he demanded that staff members skip the two-hour procedure to sterilize the equipment. Two other surgeons, however, had determined that the injuries were not life-threatening and could wait for sterile instruments. The charge nurse refused to let the patient be admitted to the OR until the instruments were sterilized, and the surgeon became irate. The surgeon threatened the nurse and began yelling and swearing at staff. He later took a swing at deputies who were called to intervene. It took three sheriff’s deputies to wrestle the doctor to the ground and handcuff him. There was suspicion the doctor was inebriated, but his refusal to blow into a breathalyzer made it impossible to substantiate. The surgeon was arrested and briefly jailed before his release on bail. His hospital privileges were suspended pending investigation by the hospital and the California Medical Board. The patient had the surgery performed uneventfully the following day.

**Sources:** USAToday.com, CBSNews.com, NBCSanDiego.com, InsideBayArea.com

Most of us have a reflexive sense of what constitutes the professional doctor or practitioner. We have little trouble identifying what we would consider exemplary professional behavior when we see it. Patients identify ideal physician behaviors as those manifest in practitioners who are confident, empathetic, humane, personal, forthright, respectful, and thorough. Iconic television characters such as Marcus Welby easily come to mind. Ironically, this image of the compassionate healer who communicates masterfully with his patients and colleagues has been replaced in modern media by Dr. House, a severely impaired and disruptive physician by almost any standard, who is the subject of a highly popular television series. While exhibiting unprofessional conduct in almost every episode, Dr. House has the mitigating attribute of being a brilliant diagnostician, an excuse that has been widely used to ignore otherwise unacceptable behavior in hospitals on TV and across our nation.

In recent years, it has become common to refer to unprofessional conduct as disruptive behavior, and the two adjectives are frequently used interchangeably. The latter term has emerged because of the complex nature of modern healthcare. Today, medical treatment is almost always delivered by interdisciplinary teams of personnel and in institutions where clinical operations involve the intricate collaboration of a multitude of departments and services. In such settings, behavior that is unprofessional invariably disrupts the smooth functioning of the various parts and players.

There have been many efforts to define “disruptive behavior.” According to one commentator, “A physician’s behavior may be defined as disruptive when it ceases to be normative ... ”

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This definition lets us know that disruptive conduct is outlier behavior but gives us little else to go on.

The AMA has described “disruptive conduct” as follows: “personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively.” The Ontario Medical Association states, “Disruptive behavior is demonstrated when inappropriate conduct, whether in words or action, interferes with, or has the potential to interfere with, quality healthcare delivery.” These statements help us define disruptive conduct by its impact, but do not provide clarity regarding specific actions that could be considered disruptive.

The Joint Commission says that “disruptive and inappropriate behaviors” are those that undermine a culture of safety. It defines these as “conduct by staff working in the organization that intimidates others to the extent that quality and safety could be compromised. These behaviors, as determined by the organization, may be verbal or nonverbal, may involve the use of rude language, may be threatening, or may involve physical contact.” This definition is helpful by providing some examples and it further informs us that organizations have the latitude to define specific behaviors that they consider a threat to quality and safety.

Often, unprofessional or disruptive conduct is recognized only when a pattern of inappropriate behaviors becomes apparent. This is because the egregiousness of unprofessional conduct follows a continuum from minor to highly significant. The gravity of any particular behavior depends on the nature of that behavior, the context in which it arises, the frequency with which it has been exhibited, and the consequences flowing from it.

It is important to differentiate between a disruptive or unprofessional behavior and a disruptive physician. The practice of medicine and work in the healthcare field are highly stressful and taxing. While physicians and other practitioners should strive for perfection, few can progress through a career without an occasional lapse in ideal behavior. The term “disruptive physician” should be reserved for the practitioner who shows a pattern of inappropriate conduct and is a chronic offender. The term should rarely be applied to a physician based on a single incident.

The range of unprofessional behaviors manifested in healthcare settings is unsettlingly broad. Newspaper stories relate incidents of physicians who have engaged in fist fights in the hospital doctors’ lounge, walked out in the middle of surgery to run personal errands, and even locked a nurse in a utility closet in a fit of pique! Staff members in healthcare institutions frequently relate episodes of verbal abuse, demeaning demands, thrown objects, and shocking temper tantrums. Patients and their families experience practitioners who are rude, insensitive, inconsiderate, arrogant, and self-centered. Physicians tell of colleagues who obstruct constructive dialogue at medical staff meetings, chart inappropriate comments.
in medical records, refuse to follow medical staff policies, and threaten retaliation when they are not given their way.

Harassment, a frequent form of inappropriate conduct by physicians, can relate to an individual’s race, age, religion, color, sex, sexual orientation, national origin, ancestry, marital status, and mental or physical disability. Some hospital policies define “harassment” as any form of physical or verbal abuse of such significant character and nature that no person of reasonable sensitivities should be expected to tolerate.

Sexual harassment in particular has, sadly, been a common occurrence in healthcare settings. Sexual harassment is considered a form of sexual discrimination that violates Title VII of the Civil Rights Act of 1964. Verbal or physical conduct of a sexual nature, unwelcome sexual advances, and requests for sexual favors are all forms of sexual harassment that are impermissible in the workplace when they interfere with an individual’s ability to perform his or her job or create an intimidating, hostile, or offensive work environment. Most states prohibit inappropriate sexual conduct between licensed physicians and patients and certain other caregivers, and many explicitly label such interactions as unprofessional behavior. Because of the large number of foreign-born health workers employed or practicing in the United States, it is important to note that disruptive conduct includes racial discrimination and harassment based on ethnicity or national origin.

In recent years, employees who argue they were subjected to a hostile workplace environment have sued hospitals. Where a coworker is subject to harassment, an employer is liable if the employee can establish that the employer knew or should have known of the harassment and failed to take prompt, remedial action. This action is reasonably expected to prevent the harassment from recurring. Hospitals that “reprimand” disruptive physicians over and over but do not take steps that actually end the harassment can be sued on grounds they permitted the existence of a hostile workplace environment.

The concept of disruptive behavior takes into consideration physician actions that damage the reputation of the hospital and its medical staff; cause a disproportionate expenditure of time, resources and money; or increase the likelihood of malpractice or other tort or regulatory liability exposure.

The term “disruptive physician” most generally conjures up images of hostile, threatening, or intimidating behavior. However, passive-aggressive behavior may be even more common. Many organizations consider disruptive conduct any actions that prevent or interfere with an individual’s or a group’s work or their ability to achieve intended outcomes. Thus, repeated failure to comply with policies such as wearing a required name tag or washing hands before entering a patient room would constitute a form of disruptive and unprofessional behavior.
## Manifestations of Unprofessional/Disruptive Conduct

- Disrespectful, demeaning, profane, vulgar, or rude language
- Yelling
- Intimidation or bullying, including threatening gestures
- Harassment
- Sexually inappropriate speech
- Sexual boundary violations/inappropriate touching or unwelcome physical contact
- Racial/ethnic slurs, insults, or innuendos
- Jokes or nonclinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance, or socioeconomic or educational status
- Throwing tirades, tantrums, or having outbursts of anger
- Slamming down objects
- Throwing objects (e.g., charts or instruments)
- Criticizing other caregivers in front of patients or other staff
- Demeaning or belittling the efforts of other caregivers
- Insults and shaming others
- Condescending or sarcastic language or tone
- Comments that undermine a patient’s trust in other caregivers or the hospital
- Repeated, intentional noncompliance with organizational rules and policies
- Deliberate interference with the smooth functioning of hospital, medical staff, or practice operations
- Inappropriate comments in medical records, especially those impugning the quality of work of others
- Unethical or dishonest behavior
- Repeated lack of response to calls or requests from other health personnel for information or assistance when on call or expected to be available
- Intentional miscommunication
- Unwillingness to work collaboratively and collegially
- Creating rigid or inflexible barriers to requests for assistance or cooperation
- Inappropriate arguments with patients, their families, hospital staff, or other practitioners (respectful discussions in which disagreement is expressed are not arguments)
- Retaliation against any member of a healthcare team who reports a conduct violation or impropriety
- Implied threats, especially retribution for making complaints
- Failure to adequately address a safety concern or patient care need expressed by another member of the healthcare team
- Nonconstructive criticism, especially when expressed to the recipient in an intimidating manner or in a manner that undermines confidence, is belittling, or implies stupidity or incompetence
- Imposition of idiosyncratic requirements on members of the hospital staff that have nothing to do with providing quality patient care
- Inappropriate use of litigation or threats of litigation
- Inappropriate or malicious gossip
- Passive-aggressive words or actions that undermine team behavior in the healthcare setting
- Refusal to follow adopted protocols

(This list is intended to be representative but not exhaustive.)
While most professionals have no problem reaching consensus on words or actions that are inappropriate, it is important to note what is not unprofessional behavior. There can be a fine line at times separating a legitimate action from one that is unprofessional. The difference may lie in the context in which a behavior is displayed, the tone with which words are expressed, or even accompanying facial expressions or other nonverbal actions. Examples of acceptable professional behavior include:

- Constructive criticism, especially in an educational context and if provided with the intention of improving patient care
- Making a formal complaint to an appropriate oversight or regulatory body
- Testifying in court against a colleague
- Good faith patient advocacy reasonably pursued using established mechanisms

**Prevalence of Unprofessional Conduct**

As previously mentioned, there is quite a broad consensus on which behaviors are considered unprofessional. Nevertheless, unprofessional conduct has been tolerated for decades, and its prevalence is alarmingly pervasive. The high status of doctors in hospital settings has historically intimidated other healthcare workers from reporting inappropriate physician behavior. A long-standing culture in medicine that champions professional autonomy and personal accountability has made physicians uncomfortable challenging the actions of their professional brethren. In the absence of consequences, those who engage in unprofessional conduct have found few barriers to continuance of their inappropriate behaviors. Some observers feel that the rate of incidence of unprofessional conduct has been rising in recent years brought on by the enormous changes taking place in healthcare and increasing stress on physicians. Others believe that we are simply calling out bad behavior more often because of increased awareness of the damage caused by so-called disruptive behavior. Today, healthcare leaders ignore unprofessional conduct at their own risk.

So just how prevalent is unprofessional conduct? It is clear that the vast majority of healthcare professionals represent the field of medicine well in both their words and actions. Although only a small percentage of physicians display patterns of inappropriate conduct, their absolute numbers are significant. As a result, disruptive practitioners are found on medical staffs and in communities all across the country.

If one is looking for a definitive answer on the prevalence of unprofessional conduct, sound data is lacking. However, numerous surveys have given us a good sense of the magnitude of the problem. In a 2004 survey of physician executives conducted by the American Association for Physician Leadership (formerly the American College of Physician Executives), more
than 95% reported encountering doctors who engaged in “disturbing, disruptive, and potentially dangerous behaviors on a regular basis.” One third of the 1,600 respondents indicated that they observed “problems with physician behavior” weekly or monthly. More than half the time, the problematic interaction was with a nurse. The remainder of the incidents involved interactions that were equally divided among other physicians, administrators, or patients and their families.

A report from 2006 estimated that 3%–5% of physicians have demonstrated behavior that interfered with good patient care or could be anticipated to interfere negatively with the processes of delivering care. At the other end of the spectrum, Wayne Sotile, PhD, a psychologist and editor of the Resilient Physician Newsletter, estimated in a 2004 article for American Medical News that about 12%–15% of doctors are chronically disruptive.

Disrespect is the most common disruptive behavior engaged in by physicians. This is closely followed by subtle intimidation, which is more prevalent than overt threatening behavior. As many physician leaders know, in the hospital setting, a significant portion of unprofessional conduct by physicians is directed at nurses. Indeed, nurses report that inappropriate physician behavior is the single most important factor with respect to their job morale and satisfaction. In a survey performed by VHA, Inc., a national healthcare alliance of more than 2,000 community-owned hospitals, more than one third of participants from over 140 hospitals reported knowledge of a nurse leaving an institution because of unprofessional conduct by physicians. Sixty-four percent of nurses reported some form of verbal abuse from a physician at least once every two to three months. It is hardly surprising that studies suggest 18% of nurse turnover is directly attributed to verbal abuse by physicians. Twenty-three percent of nurses reported at least one instance of physical threat from a physician (most commonly a thrown object).

In 2009, the American Association for Physician Leadership surveyed more than 2,100 physicians and nurses to see if progress was being made in addressing unprofessional conduct. About 30% of participants reported that “bad behavior” occurred several times a year; another 30% said weekly; and 25% said monthly. Sadly, 10% reported witnessing “problems between doctors and nurses every single day.” Ninety-nine percent of respondents said disruptive physician behavior affects patient care. The most common inappropriate behaviors were insults and degrading comments, yelling, cursing, inappropriate jokes, and refusals to work collaboratively. Some of the reported behaviors sounded like criminal assault. Thirteen percent of respondents reported witnessing acts of sexual harassment in the past year. While respondents noted that both nurses and doctors were caught acting badly, the predominance of inexcusable conduct lay with physicians.

Unprofessional interactions occur not only between doctors and nurses. Physician abuse of pharmacists and trainees, such as medical students, is also reported to be widespread.
A survey of 523 physician leaders and 321 staff physicians in 2011 found almost three quarters (71%) of respondents had witnessed disruptive behavior within the previous month. Over a quarter of those questioned admitted to having been disruptive at one time in their career. Disruptive incidents were more frequent in surgical, anesthesia, and obstetrics and gynecology specialties, and occurred more often in the stressful and high pressure areas of the operating room, intensive care unit, and emergency department.\textsuperscript{21}

### 1.1 Survey of Unprofessional Conduct Among Physicians and Nurses

From the list, choose three behavior problems between doctors and nurses that occur most often at your organization.

<table>
<thead>
<tr>
<th>Behavior Problem</th>
<th>Most frequent behavior problem</th>
<th>Second most frequent behavior problem</th>
<th>Third most frequent behavior problem</th>
<th>Rating average</th>
<th>Response count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yelling</td>
<td>58.1% (702)</td>
<td>27.4% (331)</td>
<td>14.6% (176)</td>
<td>1.56</td>
<td>1,209</td>
</tr>
<tr>
<td>Cursing</td>
<td>9.9% (61)</td>
<td>47.6% (294)</td>
<td>42.6% (263)</td>
<td>2.33</td>
<td>617</td>
</tr>
<tr>
<td>Degrading comments and insults</td>
<td>46.8% (619)</td>
<td>34.4% (455)</td>
<td>18.9% (250)</td>
<td>1.72</td>
<td>1,324</td>
</tr>
<tr>
<td>Refusing to work together</td>
<td>24.4% (103)</td>
<td>34.4% (145)</td>
<td>41.2% (174)</td>
<td>2.17</td>
<td>422</td>
</tr>
<tr>
<td>Refusing to speak to each other</td>
<td>16.3% (50)</td>
<td>41.4% (127)</td>
<td>42.3% (130)</td>
<td>2.26</td>
<td>307</td>
</tr>
<tr>
<td>Spreading malicious rumors</td>
<td>22.6% (28)</td>
<td>29% (36)</td>
<td>48.4% (60)</td>
<td>2.26</td>
<td>124</td>
</tr>
<tr>
<td>Inappropriate joking</td>
<td>20.5% (77)</td>
<td>35.1% (132)</td>
<td>44.4% (167)</td>
<td>2.24</td>
<td>376</td>
</tr>
<tr>
<td>Trying to get someone disciplined unjustly</td>
<td>13.3% (39)</td>
<td>33% (97)</td>
<td>53.7% (158)</td>
<td>2.40</td>
<td>294</td>
</tr>
<tr>
<td>Trying to get someone fired unjustly</td>
<td>5% (4)</td>
<td>22.5% (18)</td>
<td>72.5% (58)</td>
<td>2.68</td>
<td>80</td>
</tr>
<tr>
<td>Throwing objects</td>
<td>4.9% (4)</td>
<td>13.4% (11)</td>
<td>81.7% (67)</td>
<td>2.77</td>
<td>82</td>
</tr>
<tr>
<td>Sexual harassment</td>
<td>5.5% (3)</td>
<td>12.7% (7)</td>
<td>81.8% (45)</td>
<td>2.76</td>
<td>55</td>
</tr>
<tr>
<td>Physical assault</td>
<td>33.3% (5)</td>
<td>20% (3)</td>
<td>46.7% (7)</td>
<td>2.13</td>
<td>15</td>
</tr>
</tbody>
</table>

*Source: Reprinted with permission of the American Association for Physician Leadership.*
Chapter 1

Why Is Unprofessional Conduct So Prevalent?

It is unclear if unprofessional conduct is more prevalent in the 21st century than in the decades of the 20th century. As noted previously, healthcare has become more collaborative and complex in recent years, requiring physicians to display greater emotional intelligence as they interact continuously with a range of colleagues. Years of seismic change in healthcare have also created tremendous stress for many physicians whose careers have been rooted in the 20th century’s small business model of private practice. It seems that many of those who engage in unprofessional conduct are simply unwilling or unable to behave in a respectful and constructive manner in the face of rapid change and when confronted with the pressure cooker of contemporary medicine.

Some observers comment that a rise in unprofessional conduct has coincided with the growing demoralization of medical practitioners. Physicians, who are beleaguered by malpractice suits, increased scrutiny of their clinical decisions, an onslaught of regulations and paperwork, declining prestige, the frustration of poorly designed electronic health records, pressure to increase productivity, and diminishing incomes, are increasingly dispirited. Some succumb to a victim mentality, and when feeling victimized it is common to lash out at the closest or most vulnerable targets. As we will discuss, such targets are often nurses.

Another predisposing factor for problematic physician conduct is the strong emphasis medical education puts on professional autonomy. The culture of autonomy tends to be dismissive of authority and often characterizes leaders as illegitimate. This culture fosters resistance to rules, requirements, and the authority of hospital administrators and medical staff leaders. Disruptive practitioners frequently argue that they enhance the quality of care by being protectors of physician autonomy and the prerogatives of individual doctors.

Medical education and training has been described as inculcating a “culture of the expert” that creates both positive and dysfunctional attributes in the physician workforce. In addition to the emphasis this culture places on practitioner autonomy, it also emphasizes self-sufficiency, distrust of the input of others, and personal accountability. These attributes were all highly functional in medicine as practiced in the 1800s and early 1900s. They are valuable today, but must be tempered by the changed realities of medical practice in which good care relies less and less on the skills of any single person. One way in which we see this historic culture as problematic is in regard to how physicians view teamwork. Whereas most hospital staff members see teamwork as the close coordination and collaboration of a group of individuals, doctors often see teamwork as a group of individuals smartly responsive to the physician—who is the captain of the ship. To a physician, a good team is one that takes orders well. In contrast, other health workers view a good team as one where everyone is respected for their roles and skills, every individual can express opinions and give input, there are no automatic assumptions about who is right, and accountability lies with the team and not just the physician. Medical education has for
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decades trained physicians and nurses in an outdated, hierarchical model that makes the latter subservient to the former rather than equal participants on a team where everyone brings unique skills. Unfortunately, this outdated characteristic of physician training sets the stage for physicians to engage in disruptive behaviors. While many medical schools have started to educate students on the importance of effective team functioning, these minor curricular modifications have done little to change the historic and immersive culture of the expert present in our nation’s teaching hospitals.

A small number of disruptive physicians suffer from underlying illnesses. Many observers of physician misconduct assume it is indicative of a problem with substance abuse. They conclude that disruptive behavior is at such variance with professional ideals that physicians who engage in it must not be able to control their actions and are under the influence of drugs or alcohol. However, it has been estimated that substance abuse accounts for less than 10% of physician behavior problems. Major psychiatric conditions, such as bipolar disorder and depression, can present with symptoms of agitation, mania, poor judgment, and poor impulse control that result in disruptive behaviors. However, major psychiatric disease is not present in most disruptive practitioners. While a range of medical conditions can contribute to aberrant behavior, the most common contributor is a personality trait disorder. One particular subset of disruptive doctors, those who exhibit sexual boundary disorders, have been found to have character disorders in which they “tend to experience greater problems with impulse regulation and to be more self-centered, less empathetic, less likely to take responsibility for their offenses (and more likely to blame others or circumstances), and less likely to be influenced by societal norms.”

While unprofessional behavior can never be justified, it is clear that one powerful trigger is the frustration most practitioners experience with ineffective, poorly conceived, or improperly administered clinical processes. Unfortunately, such processes are too common in hospitals and healthcare entities across the continuum of care. Nevertheless, disruptive conduct is always an inappropriate response to such circumstances.

It seems clear that there are multiple contributors to the widespread display of improper behavior in medical settings. However, it can be reasonably argued that the greatest single culprit for the pervasiveness of unprofessional conduct is the tolerance of it that has existed in healthcare organizations for so long. Where physicians are the perpetrators, many hospitals are the enablers by addressing only the most egregious misconduct and ignoring less significant patterns of disruptive behavior until they reach dangerous levels. This tolerance is largely a result of ineffective physician leadership. Sadly, where disruptive behavior is routinely ignored or tolerated, the demands of these offenders are often indulged just to shut them up. This only buttresses the unprofessional conduct and leads to a reinforcing cycle of inappropriate behavior. In such environments, disruptive conduct becomes an accepted mode of doing business for some physicians.
Chapter 1

There may be more insidious reasons for ignoring disruptive conduct. In a survey published by the American Association for Physician Leadership in 2004, 40% of executives surveyed admitted that disruptive physicians who generate high amounts of revenue are treated more leniently than doctors who bring in less revenue. Sometimes in these circumstances, physician leaders are ready to step up and deal with a disruptive colleague, but they are pulled back by CEOs or hospital boards that fear the negative financial impact on the organization. Physician leaders are much less likely to do the right thing in the future when they have had the rug pulled out from under them in this manner. For this reason, it is important that unanimity is reached by medical staff leaders, hospital executive teams, and the board of trustees regarding how to resolve concerns over unprofessional practitioners.

The data outlined above make it clear that disruptive behavior continues to be highly prevalent and widespread. Despite this observation, it does appear that a clear commitment in recent years by healthcare leaders willing to address this scourge is making a difference in many institutions from coast to coast.

Factors Driving the Prevalence of Disruptive Physician Behavior

- Rapid and volatile change impacting the medical practice of physicians
- “Culture of the expert” promulgated in medical education which puts on a pedestal physician attributes that can sometimes be dysfunctional in today’s complex healthcare environments (e.g., physician autonomy)
- Substance abuse
- Health issues, including major and minor psychiatric diagnoses
- Historic unwillingness of physicians to confront colleagues over disruptive conduct
- Hospitals unwilling to discipline misconduct by high-revenue–generating practitioners
- Frustration practitioners experience with ineffective, poorly conceived, or improperly administered clinical processes

Changing Expectations: The Move to Zero Tolerance

Increasingly, physician behavior tolerated in the last century will not be tolerated in the 21st century. Perhaps the clearest marker of this change in attitude was the issuance of a Sentinel Event Alert by The Joint Commission on July 9, 2008. The alert noted that there has been a “history of tolerance of and indifference to intimidating and disruptive behavior in healthcare,” and it asserted that organizations that fail to address such behaviors through
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effective systems are, in effect, indirectly promoting it. The alert took note of a growing body of literature that correlates disruptive behaviors in the hospital setting with:

- Decreased patient satisfaction
- High staff turnover
- Medical errors
- Preventable adverse outcomes
- Increased cost of care

The Joint Commission alert also observed that patients and their families readily recognize hostility in the workplace, even when it is not directed at them. One result can be patient dissatisfaction with the professionalism of the healthcare team and an increase in the likelihood of a malpractice action. In a follow-up to its alert, The Joint Commission has promulgated Leadership Standards for hospitals that require them to create and implement a process for managing behaviors that undermine a culture of safety.

It is not just the demands of accrediting bodies that have motivated hospitals and other institutions to rein in disruptive conduct. In this age of information pervasiveness, news of egregious unprofessional behavior often appears in the press, on the Internet, in healthcare blogs and tweets, and in the ubiquitous rumor mill. The entire medical profession is diminished when these stories come to light. Hospital reputations can be tarnished for years. The careers of healthcare practitioners can be seriously derailed. To the public, unprofessional behavior by physicians is unfathomable and undermines their trust and confidence in doctors. In this era of transparency, an awareness of disruptive behavior can cause public ratings of practitioners and institutions to suffer. Furthermore, plaintiff malpractice attorneys troll for evidence of disruptive conduct in the backgrounds of physicians they are suing. The lawyers know revelation of such misconduct is an effective tactic to win a jury’s sympathies. If the attorney can show a hospital tolerated such misconduct, he or she now has the basis for bringing a corporate negligence claim against that institution (and its deeper financial pockets).

The impact of disruptive conduct on healthcare staff members has also gotten the notice of healthcare leaders. Lawsuits from nurses assert hospital negligence for ignoring abusive conduct and creating a hostile workplace environment. In such cases, the settlements or monetary judgments can be significant. Moreover, there is a clear connection between disruptive behavior and nurse turnover. The costs of recruiting, training, and retaining new nurses provides another economic rationale for addressing unprofessional behavior. Physicians looking for a medical community to join may also be put off when they see a medical
staff characterized by problematic professionals. Other staff physicians may choose to leave rather than continue with an organization that tolerates abusive colleagues. The growing shortage of physicians in the nation means that most hospitals cannot afford to tolerate barriers that jeopardize recruitment and retention.

If accreditation standards, negligence suits, reputational damage, and staff turnover are not reason enough for hospitals to stem disruptive behavior, payers have also provided incentive. For example, many private and public insurers have begun to deny hospitals payment for so-called “never events.” These are clinical occurrences that payers have determined should rarely, if ever, occur. Considerable literature on never events suggests that they occur with greater frequency where there is poor communication, collaboration, and teamwork. These elements of essential good care are undermined by the behaviors attributed to disruptive physicians.

It has become common for organizations that are cracking down on professional misconduct to declare a stance of zero tolerance. This terminology has had both salutary and negative significance. For the typical hospital, adopting a policy of zero tolerance for disruptive conduct means that it will no longer be permissible to ignore episodes of unprofessional behavior. All misconduct will be reviewed, regardless of the perpetrator and his or her status in the organization. This is a commendable position, and its widespread adoption is to be celebrated. However, some in leadership positions take zero tolerance to demand strong discipline for every breach of a code of conduct. Where zero tolerance has led to an “off with his head” reflexive reaction to every disruptive incident, the term has been a disservice to good managerial practice. As we will see throughout this text, intervening with a physician who engages in disruptive behavior takes skill and benefits from a collegial rather than punitive approach.

**Connection Between Disruptive Behavior, Patient Safety, and Quality Healthcare**

For years, evidence has been accumulating to support a connection between disruptive behavior and diminished quality healthcare and patient safety. This data demonstrates how unprofessional conduct can destabilize patient care in a variety of ways, making such behavior increasingly untenable in the hospital environment. While early efforts to reduce medical errors focused on better training and the redesign of clinical processes, the healthcare field has become acutely aware that human interaction is an important source of error that has been inadequately addressed. In the Leadership Chapter of its manual of Hospital Accreditation Standards, The Joint Commission comments that, “Behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to patient care.” According to The Joint Commission, “rude language and hostile
behavior among healthcare professionals goes beyond being unpleasant and poses a serious threat to patient safety and the overall quality of care.” 28

A 2008 report of a national survey that included 2,846 nurses, 944 physicians, and 40 administrative executives in 102 hospitals found that many of the respondents described a lack of focus in their work, along with stress and frustration, as a result of disruptive behaviors by others. Almost three quarters reported that disruptive behaviors were correlated with medical errors, two-thirds reported correlation with an adverse event, 51% correlated inappropriate behavior with compromises in patient safety, and 71% reported negative impact on quality.29 The literature in general makes it clear that disruptive conduct, at a minimum, distracts healthcare workers, whose full attention should be on the performance of their complex tasks.

Research conducted in 2006 by VHA, Inc. “found that disruptive behavior between surgeons, nurses, anesthesiologists occurs frequently in hospital operating rooms and can negatively affect patient outcomes.” 30 This negative impact on results is not surprising given the intense concentration necessary on the part of all team members when undertaking surgical procedures.

The Institute for Safe Medication Practices (ISMP) has performed numerous studies showing the connection between safe medical practices and disruptive conduct. In 2003, ISMP conducted a study involving more than 2,000 healthcare professionals, including nurses, pharmacists, and other providers. Seven percent of those answering the survey’s questions indicated that they were involved in a medication error in which intimidation played a role. According to an ISMP press release, “Almost half of all respondents (49%) indicated that past experiences with intimidation altered the way they handle order clarification or questions about medication orders. At least once in the past year, about 40% of all respondents who had concerns about the safety of a medication error assumed that it was correct rather than interact with an intimidating prescriber. Even when the prescriber was questioned about safety, almost half (49%) of respondents felt pressured into dispensing a product or administering a medication despite their concerns.” 31

In 2013, 10 years after its previous study on disruptive behavior, ISMP repeated its survey. Unfortunately, this effort revealed continuing tolerance for disruptive conduct. According to ISMP, “Despite more than a decade of emphasis on patient safety, little improvement has been made. Widespread disrespectful behaviors in healthcare persist unchecked and are found at all levels of the organization and among all disciplines of staff.” 32

In a study conducted by the American Association for Physician Leadership and Quan-tiaMD in 2011, 37% of physician respondents believed that disruptive physician behavior always impacts patient care. Another 53% held that patient care was sometimes affected. Additional studies have demonstrated that patients who are upset by the unprofessional behaviors of their doctors are less likely to be compliant with recommended treatment regimens.
Chapter 1

Consequences of Unprofessional/Disruptive Conduct

» Decreased staff morale
» Increased staff turnover
» Undermined teamwork and erosion of professional collaboration
» Reduced productivity of clinical care units
» Lawsuits alleging harassment or hostile workplace environment
» Increased malpractice litigation
» Diminished culture of safety
» Barriers to effective communication
» Increased medical errors and adverse events
» Unnecessary expenditure of financial resources
» Unnecessary consumption of administrative time and energy
» Decreased trust among healthcare personnel
» Harm to reputation
» Employee and practitioner burnout
» Increased burden on medical staff of corrective actions and fair hearings
» Difficulties in recruiting medical staff leaders
» Loss of referral business

Setting Expectations for Professional Behavior

“He who excels at resolving difficulties does so before they arise.”

—Sun Tzu, The Art of War

When confronted with concerns about their problematic behavior, many physicians are surprised to hear that their conduct is not acceptable. In some cases, they have been engaged in the behavior for many years and have only rarely, if ever, been confronted by anyone pointing out its inappropriateness. In part, these physicians have been disruptive in their conduct because no one ever told them it was wrong and had to stop. It is not an uncommon scenario for a physician leader to confront a colleague about the use of foul language in a critical care unit or operating room, only to be told by the offender in reassuring tones: “No need to worry that I’m offending anyone. I’ve been talking this way for years and nobody minds!”
Setting clear behavioral expectations is the first step to creating a culture in which disruptive conduct is rare. If a hospital or group practice does not clearly articulate its behavioral ground rules, it is not reasonable to expect everyone will know what they are. It is also unfair to hold people accountable to standards that have never been shared. If a hospital wants to enforce certain behavior expectations, it should make them absolutely clear to those who work there.

There are multiple tactics a healthcare organization can employ to communicate its expectations of professional conduct. The Joint Commission’s Leadership Standards require accredited hospitals to have a code of conduct, and HFAP also requires a “a code of ethics in the medical staff bylaws.” The use of codes of conduct is not new in healthcare settings. However, they have become more widely adopted since accreditors established these requirements. Putting a code of conduct in place should make explicit exactly what is considered unacceptable behavior at an institution. Many organizations have broad conduct codes that apply to all of their employees. However, it is prudent to have a code or set of clearly articulated behavioral expectations that apply specifically to physicians and other privileged practitioners. Many physicians, particularly those in private practice, may not feel bound by policies they believe are directed at other employees. Having a code of conduct that has been adopted by the medical staff and clearly applies to all privileged practitioners makes it abundantly clear to whom it applies. Having a code written for physicians also allows it to be tailored to behaviors unique to these clinicians. For example, such codes can address expectations for taking emergency call, responding to pages from nurses, or using electronic health records.

Most codes of conduct describe desired behaviors, often by referencing professional codes adopted by medical organizations like the AMA or the American College of Physicians. Typically, enumerated desirable behaviors are those that promote a culture of safety and quality (e.g., collegiality, the ability to work collaboratively, serving as a good team member). An example of this approach can be found in the sample code of conduct published by the organized medical staff section of the AMA in March 2009.

When composing a code of conduct, it is also important to describe unacceptable behaviors and to do so in terms that are both general and specific. For example, it is common for medical staff bylaws to indicate that “all clinical practitioners and medical staff members will treat colleagues, hospital staff, patients, and their families in a respectful and dignified manner at all times.” Although this is a valuable standard to articulate, on its own it does not provide enough specific guidance regarding particular behaviors that are considered out of bounds. The best codes will enumerate the range of behaviors deemed inappropriate. Such lists need not be exhaustive, but they should be fairly comprehensive. For example, such a code might recapitulate the items found in the table “Manifestations of Unprofessional/Disruptive Conduct” found on p. 8. The more complete the list of inappropriate...
behaviors enumerated, the less room there is for a wayward physician to argue that the actual behavior he or she engaged in was acceptable.

A code of conduct is not the only location in which to articulate appropriate and inappropriate professional conduct. Such statements can be incorporated into medical staff bylaws, medical staff policies on conduct, rules and regulations, or in a freestanding document that more broadly states performance expectations for medical staff members. In fact, the more places unprofessional behaviors are enumerated, the more likely they are to be viewed by practitioners who need this guidance. A common practice is to incorporate a code of conduct within a broader policy on conduct that discusses how the code is to be utilized and how adherence to the code will be monitored and enforced.

### Elements of a Code of Conduct Policy

<table>
<thead>
<tr>
<th>The typical medical staff conduct policy will contain several elements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>» An articulation of the standard for professional conduct, including an enumeration of prohibited disruptive behaviors</td>
</tr>
<tr>
<td>» The reporting mechanism(s) for those who observe violations</td>
</tr>
<tr>
<td>» The process for investigating allegations of unprofessional conduct</td>
</tr>
<tr>
<td>» The collegial steps that will be taken to address confirmed violations of the conduct code</td>
</tr>
<tr>
<td>» The individuals authorized to undertake these collegial steps</td>
</tr>
<tr>
<td>» The progression of interventions that can lead up to formal corrective action</td>
</tr>
</tbody>
</table>

A conduct policy should make clear how the organization will proceed when violation of the conduct code occurs. Awareness of the consequences may forestall misbehavior on the part of some practitioners. A code of conduct policy is an important risk management tool, because it ensures that unprofessional behavior is not dealt with in an arbitrary and inconsistent manner. It provides clear guidance to medical staff leaders who may not have experience working with disruptive colleagues. Where the policy encourages early intervention, it can prevent the downstream consequences of misbehavior, including the potential for patient harm, damage to the offending practitioner’s career, and legal liability for the institution.

First and foremost, the conduct policy should provide a road map for helping practitioners meet professional standards while protecting patients, staff, and the organization. Figure 1.2 is a sample of a code of conduct policy.
# 1.2 Sample Medical Staff Policy on Professional Conduct

## Policy and Procedure

### Objective

The objective of this policy is to promote optimal patient care by promoting a safe, cooperative, and professional healthcare environment by preventing or eliminating, to the extent possible, behavior that:

» Disrupts the efficient and effective operation of the hospital

» Adversely impacts the ability of healthcare professionals to do their jobs

» Creates a hostile workplace environment for hospital employees or other medical staff members

» Interferes with another practitioner’s ability to practice competently and professionally

» Disrespects or demeans patients, their families, hospital staff, or professional colleagues

» Interferes with the delivery of safe, quality medical care to patients

» Affects or impacts adversely the community’s confidence in care provided at [Hospital]

### Policy

It is the policy of [Hospital] and its medical staff that all individuals within its facilities be treated with courtesy, respect, and dignity at all times. To that end and to promote effective hospital operations, all members of the medical staff and all practitioners privileged by the medical staff are required to conduct themselves in a professional and cooperative manner at all times regardless of the circumstances. Unacceptable or disruptive behavior may include, but is not limited to, the following:

» Disrespectful, profane, demeaning, or rude language or conduct directed toward or in the presence of others

» Sexually inappropriate speech

» Sexual boundary violations/inappropriate touching

» Intimidation/harassment

» Racial or ethnic insults or innuendos

» Throwing tirades or outbursts of anger

» Throwing objects such as charts or medical instruments

» Criticizing other caregivers in front of patients or staff

» Comments that undermine a patient’s trust in other caregivers or the hospital

» Repeated, intentional noncompliance with [Hospital] or medical staff rules and policies

» Deliberate behavior that interferes with the smooth functioning of hospital or medical staff activities as determined by the MEC/hospital management

» Inappropriate comments placed in the medical record, especially those impugning the quality of work done by others

» Unethical/dishonest behavior
1.2 Sample Medical Staff Policy on Professional Conduct (cont.)

» Repeated lack of response to calls from other health personnel
» Unwillingness to work collaboratively
» Inappropriate argumentation with patients, their families, hospital staff, or other medical staff members
» Retaliation against any member of the healthcare team who reports a conduct violation or impropriety
» Deliberate destruction or stealing of hospital property, including medical records
» Failure to adequately or appropriately address a safety concern or patient care need expressed by another member of the healthcare team
» Nonconstructive criticism, especially when expressed to the recipient in an intimidating manner and/or in a manner that undermines confidence, is belittling, or implies incompetence or stupidity
» Imposition of idiosyncratic requirements on members of the hospital staff that have nothing to do with providing quality patient care
» Inappropriate use of litigation or threats of litigation

Procedure

All members of the hospital community are encouraged to report instances of unprofessional conduct. Retaliation by any practitioner toward someone who properly reports perceived unprofessional behavior is unacceptable and will be subject to medical staff discipline. All reports of disruptive or unprofessional conduct will be investigated by the hospital and/or medical staff leaders.

Where incidents of disruptive/unprofessional conduct occur, they shall be documented and addressed by medical staff leaders. Collegial interventions shall be progressive in nature as appropriate to the nature and frequency of the unacceptable conduct. Where needed, corrective action may be implemented in accordance with the due process provisions of the medical staff bylaws.

Reporting and documentation

Anyone may submit a report of disruptive or unprofessional conduct on the part of a medical staff member. Reporting forms will be available from the medical staff services department (MSSD) or office of the [Hospital Chief Medical Officer (CMO)]. Periodic staff in-services or orientations will be provided to [Hospital] personnel so they are aware of the reporting procedure. The reporting form shall include space to indicate:

» The time and date of the problematic behavior
» A factual, objective description of the behavior and any information on possible precipitating events
» Whether the behavior affected or involved a patient in any way and, if so, the name of the patient
» The impact of the behavior on patient care, hospital personnel, or hospital operations
### The Parameters of the Problem

#### 1.2 Sample Medical Staff Policy on Professional Conduct (cont.)

- Any information on actions taken in response to the behavior, if any and if known, including the date, time, place, action, and name of the person(s) intervening

- Any witnesses to the behavior of concern

Reports will have a place for the signature of the person reporting. [Anonymous reports will not be accepted.*] All such reports and any patient complaints alleging unprofessional conduct by a medical staff member will be reviewed by [CMO] and president of the medical staff, who will determine what, if any, steps should be taken to confirm the information in the report. Such steps may include interviews with the reporting party, the reported party, or others who were engaged in or witnessed the unprofessional conduct (including individuals who may have been recipients of the inappropriate behavior). The CMO and president of the medical staff may delegate the confirmation of the report to appropriate third parties (e.g., department chair) at their discretion.

Where single or repeated incidents of unprofessional conduct raise concern about possible underlying physical or behavioral health issues, the party of concern may be required to undergo appropriate health evaluations in accordance with provisions in the medical staff bylaws or medical staff policies on practitioner wellness or impairment.

Reporting parties may be informed that the matter is being addressed in accordance with medical staff policies. They may be provided with the status of an evaluation or intervention but not the details.

A copy of the report and the steps taken to verify its allegations will be kept in the confidential credentials file of the medical staff member involved.

Documentation of any subsequent fact-finding or collegial interventions will also be kept in the member’s credentials file.

#### Collegial and disciplinary interventions

The following collegial and disciplinary interventions may be utilized when unprofessional conduct is identified:

- Informal meeting with the offender to remind him or her of the conduct policy and the expectations for professional behavior. Such a meeting should also include a description of consequences of further violations.

- A written reminder of requirements to comply with the policy on professional conduct at all times.

- A formal meeting to discuss a significant incident or a pattern of unprofessional behavior.

- A formal letter of concern regarding ongoing misconduct and a description of the consequences of further infractions.

- A mandatory appearance before the medical executive committee to explain the member’s noncompliance with expectations for professional behavior.

- A formal evaluation of the offending member by an outside program or expert who deals with physicians with conduct issues.
1.2 Sample Medical Staff Policy on Professional Conduct (cont.)

» A formal evaluation of the offending member to discern any health or impairment problems which may be connected to the improper conduct.

» A letter of reprimand in the member’s credentials file.

» Imposition of a disciplinary suspension, in accordance with the procedures described in the due process/corrective action provisions of the medical staff bylaws.

» Imposition of a conditional reappointment.

» Requirement for participation in an appropriate behavioral management program.

» Loss or restriction of membership on the medical staff and/or clinical privileges.

This list is not meant to be exhaustive and medical staff and hospital leaders may consider and implement other interventions where they deem appropriate. Except as otherwise indicated in the medical staff bylaws, the interventions described above may be carried out by the president of the medical staff [and/or the Hospital CMO or an individual(s) or committee designated by the president of the medical staff and CMO]. Actions that constitute corrective action will be carried out in accordance with the appropriate provisions of the medical staff bylaws Corrective Action and Fair Hearing Manual. The priority in determining which interventions to utilize and when will depend on the need to protect patients and hospital personnel.

All interventions must be documented and the documentation kept in the offending medical staff member’s confidential credentials file.

**Education and communication**

A copy of this policy will be provided to all members of the medical staff as part of their initial orientation to medical staff policies and procedures. A copy will also be provided in the reappointment packet of each applicant for reappointment to the medical staff. From time to time and at its discretion, the medical executive committee will sponsor an educational program on professional conduct for members of the medical staff to ensure they recognize and understand the dangers that result from unaddressed disruptive conduct and to make sure they are familiar with the medical staff and hospital expectations for professional conduct.

*Author’s note: Some hospitals allow anonymous reporting of unprofessional conduct in the belief it will lower the threshold for such reporting and therefore better protect patients. Where anonymous reporting is not allowed, it is critical that there be a nonretaliation policy that provides assurance to staff members that they will not be harmed by their efforts to report appropriately.*

**Communicating the Code of Conduct/Behavioral Expectations**

Although it is important to define behavioral expectations, this effort is of little value if the expectations are not communicated effectively to the target audience. Once an organization adopts a code of conduct, it should not be allowed to become out of sight and out of mind. Whether behavioral expectations are enumerated in a code, a policy, or a list of broader performance expectations, it is essential that they be distributed widely and repetitively. For example, a conduct code might be included in every application package for medical
staff membership and privileges. It might similarly be contained in a welcome package for new practitioners to the staff and discussed during any orientation proceedings. To demonstrate that they have actually read the document, practitioners may be asked to sign a copy indicating their review and acceptance of the standards. A chief of staff or department chair might review the expectations with new members as part of a review and check-in after their first quarter on the job or as a department member. Some organizations include the code of conduct in every reapplication packet for membership and privileges. In this way, there is periodic reinforcement of the behavior standards adopted by the medical staff. Other organizations include the code once a year in their medical staff newsletter or post it prominently in the doctor's lounge or dining room. If the prevalence of problem behavior warrants it, the code of conduct may be periodically reviewed at general medical staff meetings.

In some communities, hospitals and medical staff members have negotiated a formal compact or understanding of their mutual responsibilities. These efforts are intended to clarify reasonable citizenship obligations a hospital can expect from its community of physicians and what the hospital will do for them in return. Many of these compacts explicitly address the expectation that physicians will comply with established codes of conduct. Typically, all members of the medical staff are expected to sign such a compact and adhere to the requirements it articulates.

To keep the importance of appropriate conduct focused in the minds of physicians, compliance with behavioral expectations can be addressed in periodic performance feedback reports. Such reports are now routine at most hospitals and are part of the ongoing professional practice evaluation (OPPE) required by The Joint Commission and HFAP. The Joint Commission explicitly defines OPPE as “a document summary of ongoing data collected for the purpose of assessing a practitioner’s clinical competence and professional behavior” [italics added].

The trend toward employment of physicians by hospitals has provided additional means to familiarize practitioners with behavioral expectations. It is quite common for employed doctors to undergo an annual performance review. These evaluations should include information on how well the practitioner abides by the conduct standards adopted at that institution. In doing so, physicians are reminded of the importance the organization places on professional behavior.

Reference to performance expectations should be included in formal medical staff documents. For example, language in the medical staff bylaws should clearly establish the responsibility of every medical staff member to behave professionally at all times. The requirements for staff members in these documents should specifically obligate each practitioner to comply with adopted codes of conduct and related policies on professional behavior. The bylaws and related credentialing policies should make clear that professional conduct
will be considered when evaluating applicants for medical staff membership and privileges and when evaluating a physician’s appropriateness for reappointment to the staff. In addition, medical staff governance documents should indicate that applicants and medical staff members might be required to undergo examinations by behavioral health specialists if medical staff leaders believe such assessments are necessary. To facilitate communication with practitioners on behavior issues, bylaws should include a mandatory appearance clause that requires a medical staff member to come before a medical staff committee or officer when requested to explain reported incidents of unprofessional conduct. (See sample language in Figure 2.3.)

Organizations that have thoroughly indoctrinated their practice community about expected behavior standards often evolve a culture in which enforcement becomes a subtle and natural process of collegial peer pressure. In these settings, both physician and nurses feel comfortable pointing out to their colleagues when behavior deviates from the group expectations, and typically there is less need for someone with formal authority to step in and intervene. Of course, the greatest benefit of setting and effectively communicating clear expectations is that most practitioners will self-policing their own behavior. Where this is the case, collegiality is enhanced and the need for disciplinary action against a physician to address a pattern of misbehavior rarely occurs.

**Reporting Unprofessional/Disruptive Behavior**

It is difficult for an organization to respond effectively to unprofessional conduct if it does not know if and when it is occurring. It is therefore incumbent on hospitals and group practices to educate their communities on how to report unprofessional and disruptive behavior. At orientation or through periodic in-services, staff members of healthcare organizations should be instructed on the proper responses to observed instances of misconduct. Each staff member should understand his or her options to go up the chain of command in alerting superiors of these incidents. There should also be formal mechanisms for reporting these incidents in writing or electronically. (For an example of a reporting form, see Figure 1.3) These mechanisms should be codified in written policies that are easily accessible for each staff member to review. Many organizations allow such reports to be tendered anonymously to encourage their submission. The rationale is that in pursuit of an effective culture of safety, there should be few barriers to reporting. The ability to relay concerns anonymously is felt to be necessary, because unprofessional behavior often involves the intimidation of staff members. Individuals might be fearful of reporting incidents where there is likelihood an intimidating perpetrator will learn who brought the matter to official attention. In addition, the close working relationships necessary in many healthcare settings (e.g., the operating room or a special care unit) could be undermined where one member knows that another reported an incident of misconduct.
Other organizations insist that submitted reports of misconduct be signed. They believe this requirement is important so that complaints of unprofessional or disruptive conduct can be adequately investigated. Requiring a signature also allows the organization’s leaders to determine if one individual or many are submitting multiple complaints. Concerns expressed repeatedly by only one party may reflect an interpersonal conflict between the reporter and reported or be a manifestation of a grudge or personal animosity. Conclusions about the validity of reports are usually easier to reach when they come from diverse sources. When a matter is reduced to a “he said, she said” set of claims, it can be difficult to determine whose description of events is accurate. When a physician’s account is at variance with the reports of numerous reporters, the credibility of his or her position may be diminished.

The danger of requiring signed reports is that many staff members may simply decide it is too dangerous to submit them. In such circumstances, a problem practitioner’s behavior may have to reach a high level of egregiousness before it becomes known to leaders and can be addressed. This delay can put patients, staff, and the offending practitioner at greater risk. Where organizations require signed reports, it is critically important that they adopt a nonretaliation policy. This policy should be communicated effectively and must be strictly enforced.

Reports expressing concerns about disruptive behavior/unprofessional conduct should not be referred to as “incident reports.” Such reports should be clearly identified as peer review data and provided to an appropriate peer review body or an individual acting on behalf of an identified peer review body. If these reports are reported through a risk management process and loaded into an occurrence databank, they may not be entitled to protection from legal discovery. State courts are often reluctant to allow risk management reports protection from the legal discovery process. In order to maximize available potential for peer review protections under state law, reports describing physician specific misconduct should be clearly identified as a part of the peer review process.

Reports are the most common method for bringing episodes of misconduct to light. A more dramatic tool for drawing attention to disruptive behavior in some institutions has been the use of a Code Pink alert. Code Pink is called when an incident of abusive behavior is occurring somewhere in the hospital. Those who respond stare at the offender (or otherwise intervene if necessary) until the egregious behavior stops.37 In other institutions, this approach is referred to as a Code White. In these cases, someone pages a designated team to intervene in real time during a disruptive event.38 Team members might include the hospital’s chief nursing officer, chaplain, risk manager, vice president of medical affairs (VPMA), or others who can bring both moral weight and, if needed, administrative authority.

One group for whom more work needs to be done to encourage reporting of misconduct is physicians themselves. According to one national survey, almost one half of physicians who were aware of an impaired or incompetent colleague did not report this information.39
Although data is lacking, it is reasonable to assume that the reporting of observed unprofessional behavior is even less common among physicians.

**Medical Staff and Group Practice Credentialing: Holding the Gates Against Disruptive Practitioners**

It is often observed that the best predictor of future behavior is past behavior. Practitioners who have displayed unprofessional conduct in the past are more likely to do so in the future. The recidivism rate among disruptive doctors is high. The best way to protect an organization from disruptive practitioners is to not let them in the door in the first place. This means that those recruiting, hiring, and employing physicians need to be watchful for indicators that a practitioner has been problematic in the past and might be in the future. When a practitioner applies to a medical staff, a robust credentialing process should provide a barrier to weed out individuals who have serious misconduct in their backgrounds. The same is true of the vetting process when hiring physicians into group practices or as hospital employees.

In assessing applicants, an important step is to ask bluntly if they have ever been counseled, reprimanded, given a formal warning, put on probation, or been disciplined in any fashion for unprofessional or disruptive behavior. The medical staff bylaws should clearly state that the omission of significant information on an application is grounds for terminating the application process or for immediate loss of membership and privileges if the omission is discovered after they have been appointed. The same, of course, should be true for misstatements and fabrications on the application.

There are multiple ways to identify problematic practitioners at the time of recruitment and credentialing. One standard approach is to solicit the input of references. References should be chosen for their ability to provide useful information, including input on the professionalism of the applicant. Most organizations ask references to complete a questionnaire they provide so that specific questions can be posed. The following are examples of questions regarding conduct that are commonly asked of references:

- Has this practitioner ever been disciplined or reprimanded for unprofessional or disruptive conduct?
- Does this practitioner get along well with other staff members and colleagues?
- To your knowledge, has this practitioner ever violated a healthcare organization’s code of conduct?
- Is this practitioner a good team player and contributor?
- Has this practitioner ever been the subject of an investigation for inappropriate behavior?
# 1.3 Reporting Form for Incidents of Unprofessional Behavior

All personnel at [Hospital] are expected to report occurrences of unprofessional conduct or unsafe behavior. Such reporting is essential to our culture of excellence and to keep our patients and staff safe. Retaliation of any kind for the submission of an incident report will not be tolerated. To help ensure an adequate investigation of the incident being reported, please complete as much of the following information as possible.

1. **Date, time, and location of the incident:**

2. **Name of the individuals(s) engaged in inappropriate behavior:**

3. **Name of all parties involved in the incident, including employees, medical staff members, patients, and their families:**

4. **Identify any additional parties who were witnesses to the incident:**

5. **Describe the unprofessional behavior observed and the circumstances under which it occurred to the best of your knowledge:**

6. **Describe any impact the incident had on patient care or hospital operations:**

7. **Describe any actions taken to address the incident when it occurred or in its immediate wake, such as intervention by a supervisor, apologies, discussions with a patient or family member(s), calls to supervisors or hospital leaders, submission of complaints, etc.**

8. **In a follow-up to this report, someone will contact you. Please indicate the best means to get in touch with you (e.g., cell phone, in your office or workspace, etc.) and if you have any concerns about being contacted while at work.**

Submitted by ___________________________ Date ____________________

(Note: It is the policy of [Hospital] to have incident reports signed so they can be adequately investigated and acted upon. However, reports will be kept confidential to the greatest degree possible. If you are subjected to any retaliation or intimidation for submission of a report, you should immediately contact your supervisor or the director of human resources.)
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Where a written reference provides any hint that a practitioner might be less than professional at all times, a phone call is warranted. Many references will be hesitant to put concerns about disruptive behavior in writing. Some institutions routinely call references in an effort to obtain the most forthright information about an applicant.

Credentials committees often dismiss vague red flags suggesting applicant misconduct on the grounds that they are hearsay and unsubstantiated. They too quickly assume they cannot obtain more definitive information about past unprofessional behavior. This has often led to the appointment of a potentially problematic physician even when medical staff leaders harbor serious reservations about that individual. If rumors about unprofessional conduct surround an applicant, references can be asked pointed questions to disprove or validate them. For instance, what can be done if someone on the credentials committee has heard from a nurse that an applicant is a tyrant in the operating room at another hospital? The information so far is hearsay and needs further substantiation. At this point, a credentials committee might ask the applicant to provide the following additional information:

- **References from the following people at the hospital where alleged improper behavior occurred and/or the last hospital where the applicant worked regularly:**
  - Chief of surgery
  - OR supervisor
  - Chief nursing officer
  - Vice president for medical affairs (or equivalent)

- **Each of these references must answer the following questions:**
  - Has the applicant ever displayed unprofessional or disruptive conduct in the OR? If so, rarely or regularly?
  - Do nurses feel intimidated by the applicant?
  - Is the applicant a good team player in the OR? Has the applicant used inappropriate language in the OR on multiple occasions?
  - Has the applicant been reprimanded for inappropriate behavior in the OR?

An applicant who balks at providing these references should be told his or her application cannot be processed until the requested information is received. Where a requested reference form is not returned, the medical staff bylaws and credentials policies should make clear that it is the applicant’s burden to obtain all information requested by the hospital so it can meet its responsibility to appoint appropriate practitioners. Figure 1.4 provides a sample letter that could be sent to an applicant under such circumstances.
Disruptive practitioners often intimidate the individuals from whom a hospital seeks references by threatening a lawsuit for defamation or tortious interference with their business prospects. These are clear attempts to muzzle communication about previous problems. Even when no overt threats are made, those who are asked to provide information about an applicant based on their firsthand knowledge are often well aware of the litigious temperament of the individual in question. One way to help ease references’ fears is to require the applicant to provide a specific release ensuring he or she will bring no legal action if these references are forthcoming with information. In the event such a release is requested but not executed, no further processing of the application should take place. Figure 1.5 is a sample of such a release.

If references or other sources (e.g., a National Practitioner Data Bank report) provide evidence that action was taken against an applicant at another hospital for unprofessional conduct, additional inquiries should follow. Ask the institution that took the action for a written description of the events that transpired. (Unfortunately, such queries often go unanswered). In addition, the applicant should be asked to submit all information he or she has in possession that would give insight into the matter. Examples might be correspondence between the practitioner and hospital officials, formal letters of reprimand, reports of external review bodies, and so forth. A sample letter in support of such a request can be found in Figure 1.6. If the applicant has been the subject of a fair hearing relating to unprofessional conduct, he or she should be asked to provide the credentials committee with a written transcript of the proceedings. While another hospital might be unwilling to share such a transcript, the physician who is the subject of a hearing is entitled to receive a transcript and share it at his or her discretion.

Several studies have noted that evidence of a predilection for disruptive conduct often surfaces during medical training. In one case-control study, disciplinary action taken against physicians by medical boards was closely correlated with unprofessional behavior exhibited by those physicians in medical school. Another retrospective study showed evidence that poor performance on behavioral and cognitive measures during residency are associated with greater risk for state licensing board actions against practicing physicians.

A 2008 article in the Journal of the American Medical Association noted, “Educators have been criticized for not teaching and rigorously assessing the core values of medicine that determine professionalism.” The authors went on to describe measurements that can be used in residency training to assess various parameters of professionalism. A growing body of research suggests that it is valuable for credentials committees to query references from an applicant’s educational background (typically the applicant’s residency program) to determine whether antecedents to disruptive conduct were manifest during that individual’s training.
Dear Applicant,

The review of your application for medical staff membership/privileges has been discontinued because [name and title or reference] has not provided us with a written reference.

This reference is essential to our ability to fully evaluate your application, and we cannot resume the evaluation of your application until it is received. It is your responsibility to provide our medical staff and board with the information they deem necessary to determine whether membership/privileges should be granted.

We encourage you to contact this reference and expedite delivery of this written response to our reference questionnaire. If this information is still outstanding after 45 days, your application will be considered withdrawn. If you have any questions regarding this letter, please do not hesitate to contact me or the director of medical staff affairs.

Sincerely,

[Chair, Credentials Committee, or VPMA, or Chief of Staff, etc.]
1.5 Sample Special Release for Information Regarding Unprofessional Conduct or Other Sensitive Peer Review Matters

I hereby request that [the Facility, Person, or Persons] provide [inquiring Hospital] with all information relevant to my application for membership and/or clinical privileges at [inquiring Hospital]. This includes information relevant to my professional qualifications, credentials, clinical competence, character, ability to practice medicine safely and competently, ethics, professional behavior, or any other matter reasonably having a bearing on my qualifications for initial and continued appointment to the medical staff. This authorization includes the right to inspect or obtain any and all communications, reports, records, statements, documents, peer review findings, recommendations, or disclosure of [the Facility], the Facility's medical staff, their authorized representatives, or appropriate third parties that may be relevant to such questions. In addition, I specifically authorize [the Facility] to release information to [inquiring Hospital], its medical staff, or authorized representatives upon request.

I hereby release from liability and grant immunity to [the Facility], to any physician on the Facility's medical staff who is or was involved in reviewing my practice and qualifications for membership and/or clinical privileges, and to [name any other individual or parties] for providing information that they believe will assist [inquiring Hospital] in making a decision regarding my appointment and/or request for clinical privileges.

Physician ____________________________ Date ____________
Dear Dr. Rude,

During the review of your application for appointment, it has come to our attention concerns were raised at [other Hospital] regarding unprofessional conduct on your part. In order to complete an assessment of your application, the credentials committee must understand the nature of these concerns more fully. To facilitate our work in this regard, please provide the following information:

1. Any correspondence between you and medical staff leaders or hospital officials on the matter of unprofessional or disruptive conduct

2. Reports generated by any medical staff committees that investigated or reviewed concerns regarding your professional conduct and behavior

3. Copies of any correspondence between the hospital and any legal representative working on your behalf

Once our committee has received this information, we will continue to process your application. If this information is not provided within [ ] days, your application will be considered voluntarily withdrawn. If you have any questions regarding this request, please contact me directly or ask to speak with our hospital’s Chief Medical Officer.

Thank you for your cooperation with our credentialing process.

Sincerely,

Chair, Medical Staff Credentials Committee
Interviewing potential new medical staff or group practice members can be a helpful tactic in revealing problem personalities. In an interview, a practitioner can be asked how he handles himself when he gets angry or how he would respond to various scenarios that sometimes trigger inappropriate behavior. The applicant might be asked what the proper response is from a nurse who observes unprofessional physician conduct in the hospital. Failure of the applicant to acknowledge the reality of disruptive conduct or failure to concede the importance of reporting its existence should be a red flag. In general, practitioners “who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior.”

When a credentials committee or medical executive committee (MEC) has serious concerns about the potential for an applicant to become a conduct problem, it might also request that the individual undergo a formal behavioral evaluation. There are specialists and organizations around the country that focus on the assessment of behavioral problems in professionals (see Resources for Managing Impaired Physicians listed in the appendix). If concerns continue to exist, the hospital board has the option to grant an applicant a conditional appointment—one in which professional behavior will be closely monitored and any code of conduct violations become grounds for immediate dismissal. Figure 1.7 provides sample language for a conditional appointment.

**Medical Staff Bylaws and Disruptive Physicians: Issues to Be Addressed**

It is important for medical staff governance documents to provide a strong basis for addressing unprofessional and disruptive conduct. Medical staff bylaws or related policy documents should contain provisions that address or accomplish the following:

- Make explicit reference to the requirement to comply with any disruptive conduct policy, code of conduct, or other relevant documents relating to proper professional behavior and the processes for dealing with noncompliance.

- Clearly place the burden of producing any requested information regarding a history of disruptive conduct (or any other impairment) on the physician. This burden should exist not only at the time of appointment/reappointment but also at any time a peer review committee of the medical staff requests such information.

- Declare that at the time of application to the medical staff for membership and/or privileges, any failure to disclose requested information shall cause the processing of the application to be terminated. This shall not be considered an adverse professional action and will not give rise to due process or fair hearing rights under the medical staff bylaws.
1.7 Letter Informing Applicant of a Conditional Reappointment

Dear Dr. Disruptive,

The board of trustees, after careful consideration of your application, has granted you a conditional reappointment for a period of [one] year. During this time, continued membership/privileges are contingent upon your compliance with the following conditions:

[List all conditions here] [e.g., complete compliance at all times with the medical staff code of conduct]

Should you fail at any time to meet the conditions listed above, your status on the medical staff will be reviewed immediately and appropriate disciplinary or corrective action undertaken.

Sincerely,

CEO, Memorial Hospital

Cc: Chair, Board of Trustees
President of the Medical Staff
Department Chair
• If an applicant provided false information, misrepresented information, or omitted significant information, the physician can be terminated upon discovery.

• All applicants agree to strictly adhere to all medical staff and hospital policies on professional behavior, including any codes of conduct.

• Set the obligation that physicians must report any impairments (as defined in the bylaws) or actions taken at another hospital or healthcare organization based on impairment or disruptive conduct (including but not limited to reprimands, mandatory leave of absence, suspensions, restrictions on privileges, or terminations).

• Articulate that all medical staff members have a professional obligation to report any reasonable suspicions of impairment or any significant unprofessional conduct.

• State that all medical staff members must undergo appropriate physical or psychological evaluation if requested by an authorized medical staff leader, chief medical officer/VPMA, or the MEC Failure to cooperate in such an assessment may be grounds for suspension.

• Establish that whenever suspected deviation from professional practice is identified, a practitioner may be required to attend a meeting with a medical staff officer, department chair, or standing or ad hoc committee considering the matter. Failure to attend the meeting when asked, unless excused for good cause, may be considered an immediate and voluntary relinquishment of medical staff membership and privileges.

References

1. For examples of medical oaths in ancient Chinese and Indian cultures, see Ancient Indian and Chinese medical oaths and the comparison of their medical rules. (2001) Yeni Tip Tarihi Arastirmalar, 7, 65–76.


9. AMA Policy H-140.918.


22. For an excellent exposition on the “culture of the expert” and its impact on physicians, see *Inside the Physician Mind*, by Joseph S. Bujak, Health Administration Press, 2011.


25. Adams, Ibid.


30. A description of the VHA findings can be found at www.vha.com/AboutVHA/PressRoom/PressReleases/Archives/Pages/060705b.html.


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34. Healthcare Facilities Accreditation Program. (2014). 2014 accreditation requirements for acute care hospitals, standard 03.01.05.


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MANAGING PROBLEM PRACTITIONERS
A Leadership Guide to Dealing With Impaired, Disruptive, Aging, and Burned-Out Clinicians

Managing Problem Practitioners: A Leadership Guide to Dealing With Impaired, Disruptive, Aging, and Burned-Out Clinicians is the medical staff's answer for developing policies and procedures that address physician impairment, disruptive behavior, and problems associated with aging. Expert Todd Sagin, MD, JD, provides the guidance the medical staff services department needs to develop and implement a process for assessing and resolving legally compromising situations. Don't get caught unprepared—reduce your lawsuit risk and keep your patients and clinicians out of harm's way.

This book will help you:

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• Take the proper steps when physicians fail to correct their behavior
• Design a physician wellness committee that is supportive of the medical staff
• Set and communicate clear expectations of physician behavior and competency

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