THE DISRUPTIVE PHYSICIAN
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ISSUE

Some hospital staffs have at least one physician that is "disruptive" in the smooth running of the hospital or medical staff. What is meant by disruptive and how is the situation best handled? Due to space constraints there will be no discussion of sexual harassment.

DIAGNOSIS

Who is "disruptive"? Is it the physician who advocates, even in a loud manner, for better patient care? Is it the physician who advocates for the "vocal minority" of the medical staff, the loyal opposition? Although these physicians may cause consternation to the hospital administration, I do not believe they fall under the heading of those the medical staff would want to discipline.

The medical staff bylaws, as reviewed by an advocate retained by the medical staff who has experience with the physician perspective in the medical staff bylaws, should be the guide. The reason for the independent review is there is a potential for a conflict of interest between the hospital and the medical staff, especially as the medical staff represents the physician's interests. The bylaws, rules and regulations or policy should specify in its definitions what is meant by "disruptive" and define the nexus to quality medical care. This may be a statement that the physician applying for initial membership or reappointment will be able to work with others as to not cause adverse patient care. Vague phrases such as "cooperatively" should be avoided. In all cases of initial appointment the burden of proof is on the physician to show their ability to work well with others and not cause a problem with the quality of medical care. On reappointment the burden would be on the charging party, the medical executive committee.

Repeated acts of uncontrolled anger as manifested by yelling or other verbal abuse towards patients, visitors, hospital personnel, other physicians or any one act of physical abuse toward any person should never be tolerated. This type of incident would be the underlying tenet of the disruptive physician, their inability to get along with others as a cause for deteriorating patient care. If a nurse is afraid to call a physician for fear of being verbally castigated and a potential for harm to the patient results, this is a disruptive act or verbal harassment. The main points above are the repeated verbal acts or one single physical act and the causation element of decreased quality of care. Both must be present.

If a physician rarely blows up and/or when investigated the incident is potentially justified, there is no need to proceed further. If a physician sends multiple letters to the Chief of Staff regarding what he/she perceives as poor patient care or poor performance by any hospital employee or administrator or medical staff officer, this is opinion and does not effect patient care either directly or indirectly. Since this is done via formal channels and there is no causation, no disciplinary action is required.

DIFFERENTIAL DIAGNOSIS

If a physician is acting unprofessionally as defined by repeated verbal harassment causing problems with patient care, the medical staff should look to the underlying reasons. This is especially true if this is a new behavior. There may be physical as well as mental causes for the behavioral change. Many physicians, especially in this age of managed care with more requirements and less income, may have significant stress in their professional or personal lives. This stress may lead to alcohol or drugs. The medical staff needs to be aware of the legal aspects of the Americans with Disabilities Act and may need to hire appropriate independent legal counsel. The new JCAHO requirements starting in 2001 also address this issue (see www.jcaho.org).

TREATMENT

The Medical Executive Committee needs to establish a well thought out policy for dealing with the disruptive physician or verbal harasser. The policy should be disseminated to the entire medical staff for their approval via an insertion into the medical staff bylaws or rules and regulations. It should also be distributed to all hospital employees. This policy should include time lines for investigation and the handling of the disruptive act. Once a policy is in place, it must be followed. Do not back down if the physician threatens to sue for antitrust, defamation or other actions.

In the past a senior member of the medical staff and a friend would informally discuss the problem with the physician. This is probably still the best first step in the diagnosis and treatment of the individual. A medical staff wellness or assistance committee, where confidential discussions may take place, may be the next appropriate referral. This may show the physician is impaired and therapy may rehabilitate the physician, so the community may not lose an otherwise good doctor. Even if the physician agrees voluntarily to obtain help, vigilance and close follow-up must be performed. More formal action is indicated if the disruptive acts continue. If a physician refuses to meet with the wellness or other medical staff committee regarding the conduct, immediate suspension of privileges would be appropriate until a meeting is held if is believed by the Chief of staff that the potential for repeated disruptive behavior poses a significant threat of patient harm. If the physician's behavior does not pose an imminent risk to patient safety, a meeting should be held by the MEC and a formal peer review should be initiated. To just wait and potentially not re-appoint the physician at the next reappointment period would not be adequate since it may be two years hence and would still require a formal hearing.

Formal action would consist of a disciplinary hearing. The medical staff needs to have clearly documented and persuasive evidence of repeated disruptive behavioral acts that placed patient(s) at risk for an adverse outcome. This evidence, however, should be relatively recent. Actions that happened longer ago than the two prior reappointment periods may not be relevant to the current action unless it was part of a continuous string of events.

One hospital consultant believes that if a hospital removes the physician solely upon disruptive conduct, the physician need not be afforded a "fair hearing" as defined by medical staff bylaws.

Their sample policy goes on to state that only a single appeal to the board will be permitted. If the board is unclear whether the conduct was disruptive, they may seek the expert opinion of an impartial individual experienced in such matters. This policy flies in the face of the legal definition of due process where the same group is both the trial court and the appeal board. Although the board is responsible for the final decision as to who is on the medical staff, this type of unilateral decision may lead to a significant political backlash by the medical staff and possible legal action against the hospital.

The formal action against a Licensed Independent Practitioner for quality of care issues by the medical staff and finally by the hospital board must follow the rules of due process as outlined by the Health Care Quality Improvement Act or the equivalent State law and the medical staff bylaws. This means there must be a notice of all specific charges against the physician and an offer of a formal fair hearing and appeal processes. Rarely, since disruptive behavior is something that happens over time, is summary suspension appropriate.

If the physician’s medical staff membership and/or privileges are reduced or revoked due to the disruptive influence on the healthcare team’s ability to give good quality patient care and the physician sues, both federal and state courts have usually sided with the hospital. Several New Jersey courts have stated that all the hospital needs to establish is "prospective disharmony will probably have an adverse impact on patient care." An Ohio court of appeal decision allowed the hospital board to overrule the medical staff and refuse reappointment on grounds other than professional competence to a physician who made public comments critical of the hospital. As stated above these decisions, as well as California and West Virginia decisions that favor the physician link the questionable behavior to a decrease in quality of care.

If the disruptive physician is a contract physician their contract may be cancelled or not renewed. There is a split of opinion as to whether these physicians must be given a formal hearing. Some hospital consultants state that since only the contract is lost and not privileges, a reportable event has not occurred and no hearing is necessary. The counter argument as advanced by attorneys representing the physicians state that since the definition of a disruptive physician is conduct that adversely effects the quality of patient care, it is a reportable offense and deserves a full hearing.

In summary, a disruptive physician is usually one who over time and by the use of verbal harassment causes a disruption and potential for decreased quality of patient care. These physicians may, depending on the circumstances, be dealt with in a variety of ways from a friendly discussion to loss of staff membership and privileges.

DISCLAIMER: Although this article is updated periodically, it reflects the author's point of view at the time of publication. Nothing in this article constitutes legal advice. Readers should consult with their own legal counsel before acting on any of the information presented.

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