

American Health Lawyers Association

2010 Annual Meeting and In-House Counsel Program

***“Managing and Moderating the
Disruptive Clinician:
Legal and Practical Strategies”***



Center for Patient and
Professional Advocacy
at Vanderbilt

Dealing with Disruptive Behavior

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A Case of Never on Wednesday

Case: Never on Wednesday

- Daughter reported: “The doctor my mom was to see entered the ED acting agitated... talked down to girl at desk: “Answer my questions immediately with a yes or no...don’t need any extra conversation...I’m here to see one of my patients.” Receptionist replied “no,” and said, “but there’s the consult we called about.” Dr. became even more upset...”

The story continues:

- “Sensing that the doctor was in a hurry, I said that my mom was ready to be seen. Dr. whirled toward me, made a “T” sign with his hands and barked, ‘Time out! It’s not your turn to talk!’ Turning back to the receptionist, he demanded, ‘Who consulted me?...’”

The doctor walks out

- “Dr. yelled so the whole area could hear, ‘*You* didn’t do anything wrong. The *staff* did!...You need to go where they know what they are doing...I don’t do consults on Weds... months before I can book you an appt.’”
- “Then he turned and left me standing there. I don’t think that was very professional.”
- What might a member of your team do if they witnessed this event?



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Is this stuff just going to
happen?

And, what does this have to do
with safety?

Professionalism and Self-Regulation

Conceptual Framework – Professionalism

- Physicians have joined a profession
- Professionals commit to:
 - Confidentiality
 - Clear and effective communication
 - Modeling respect
 - Being available
- Professionalism promotes teamwork

Professionalism and Self-Regulation

Professionalism demands self-regulation

- Personal
- Discipline specific
- Group
- Systems focused

All require the skills to provide and receive feedback

Definition of Disruptive Behavior (DB)

Behavior that interferes with work or creates a hostile environment, e.g.:

- verbal abuse, sexual harassment, yelling, profanity, vulgarity, threatening words/actions;
- unwelcome physical contact; threats of harm; behavior reasonably interpreted as intimidating;
- passive aggressive behaviors: e.g., sabotage and bad-mouthing colleagues or organization
- **behavior that creates stressful environments and interferes with others' effective functioning**



1981 New Nurse
OB - Dr. X

Case: Never on Wednesday

If such an event occurred, what % of the time would a member of your team refer the patient & family to Pt Relations?

If such an event occurred, what % of the time would a member of your team have a conversation with Dr. ___?

1. 0%-20%
2. 20%-40%
3. 40%-60%
4. 60%-80%
5. 80%-100%



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Why are we so
hesitant to act?

I think the nurses contributed to his frustration.

We can't do anything, we'll get sued.

The Black Hole



Just talk to him. I'm sure he didn't mean it.

The nurses are against him.

Barriers to Addressing DB

- Lack of policies to deal with disruptive behaviors: **30%**
- Lack of awareness of the impact of disruptive behaviors on outcomes: **30%**
- Lack of training to deal with disruptive behaviors: **48%**
- Leaders don't apply policies consistently: **69%**

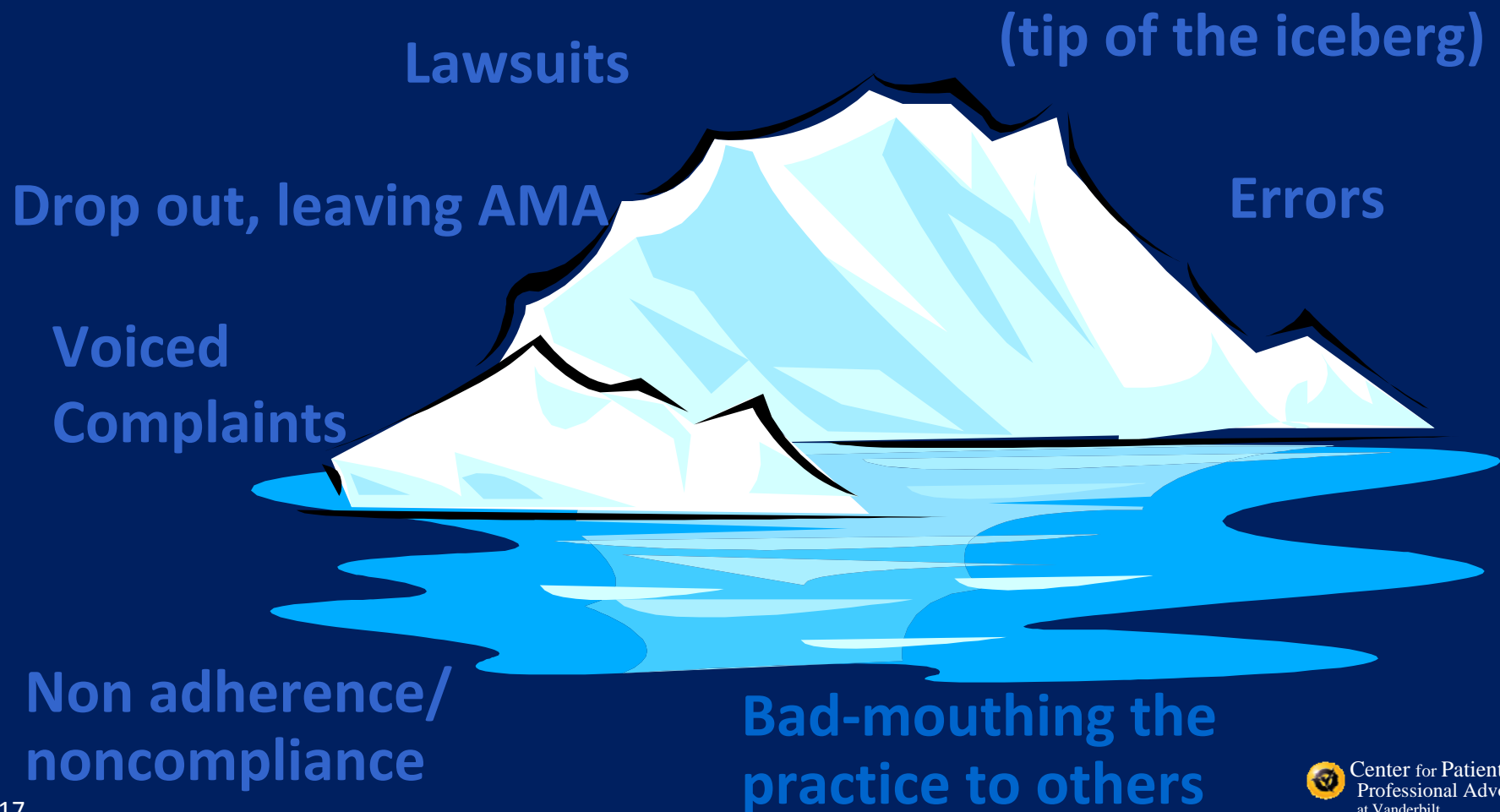
June 2009, Unprofessional Behavior in Healthcare Study, Studer Group and Vanderbilt Center for Patient and Professional Advocacy



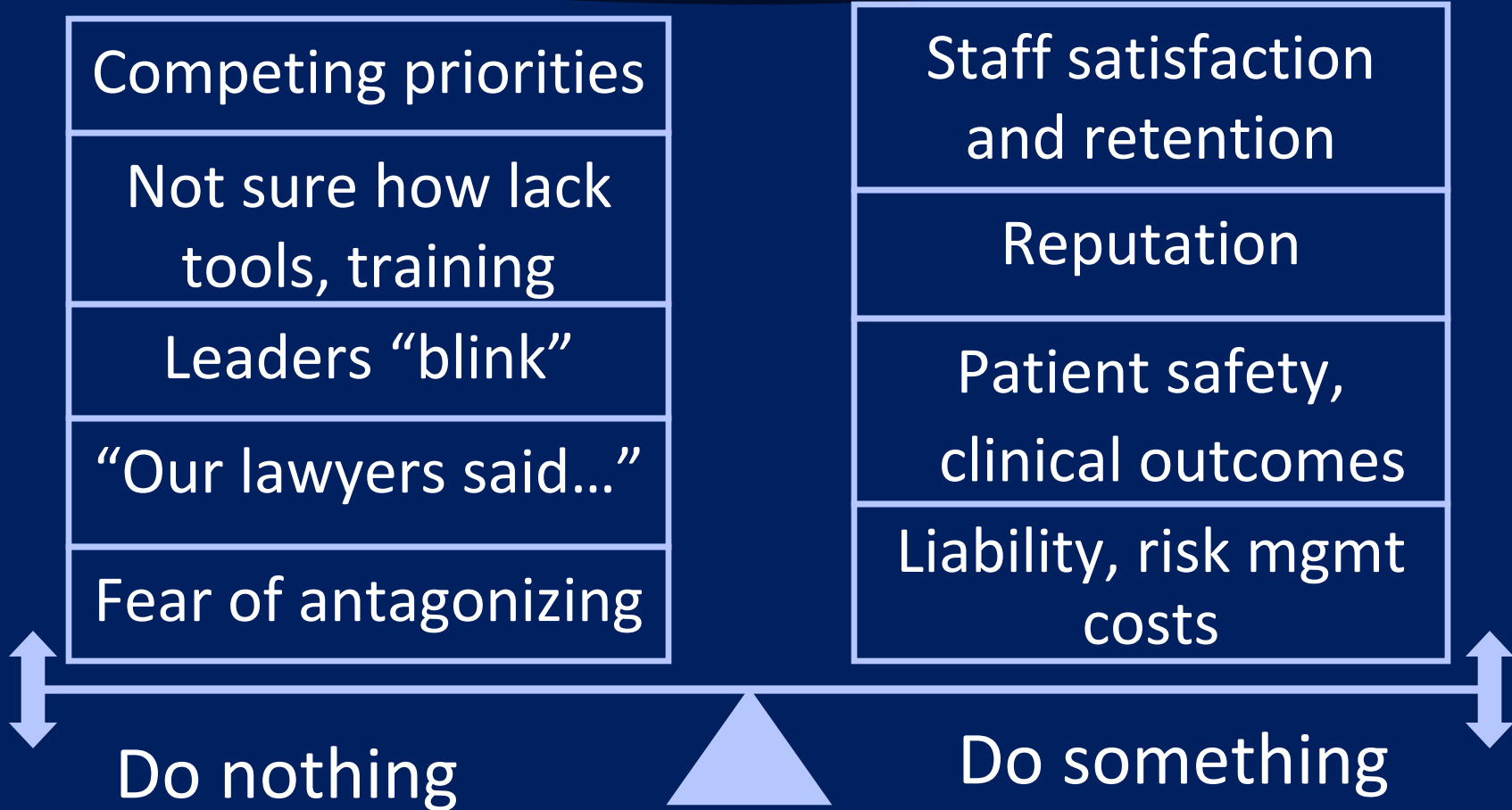
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Why bother dealing with disruptive behavior?

Consequences of Disruptive Conduct: Patient Perspective



The Balance Beam

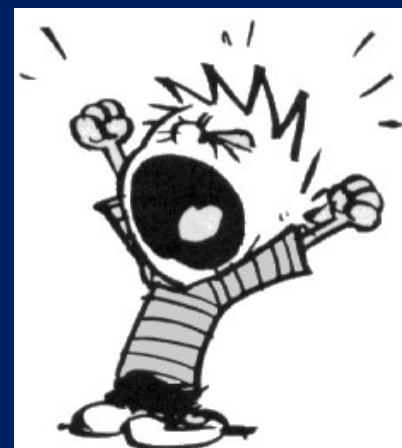


Why Might a Medical Professional Behave in Ways that are Disruptive?

1. Substance abuse, psych issues
2. Narcissism, perfectionism
3. Spillover of family/home problems
4. Poorly controlled anger (2° emotion)/Snaps under heightened stress, perhaps due to:
 - a. Poor clinical/administrative/systems support
 - b. Poor mgmt skills, dept out of control
 - c. Back biters create poor practice environments

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

5. Make others look bad - for some advantage
6. Distract from own shortcomings
7. Family of origin issues—guilt and shame
8. Well, it seems to work pretty well (Why? See #9)
9. No one addressed it earlier (Why?)



Samenow CP. Swiggart W. Spickard A Jr. A CME course aimed at addressing disruptive physician behavior. *Physician Executive*. 34(1):32-40, 2008.

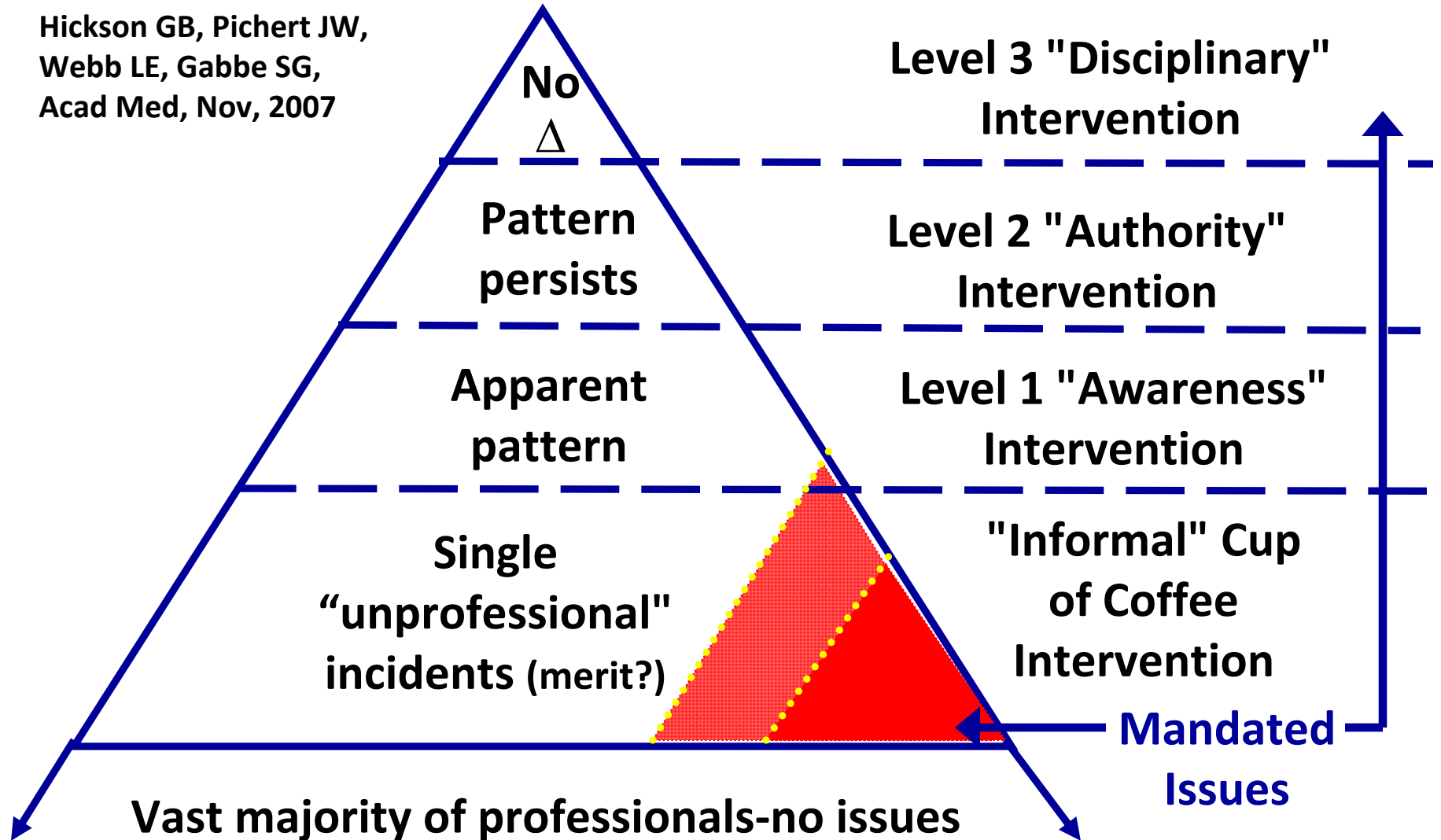
Infrastructure for Addressing Disruptive Behavior (DB)

1. Leadership commitment
2. Supportive institutional policies
3. Surveillance tools to capture pt/staff allegations
4. Model to guide graduated interventions
5. Processes for reviewing allegations
6. Multi-level professional/leader training
7. Resources to help disruptive colleagues
8. Resources to help disrupted staff and patients

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

Disruptive Behavior Pyramid

Hickson GB, Pichert JW,
Webb LE, Gabbe SG,
Acad Med, Nov, 2007





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But can this really make a
difference?

You can't really...

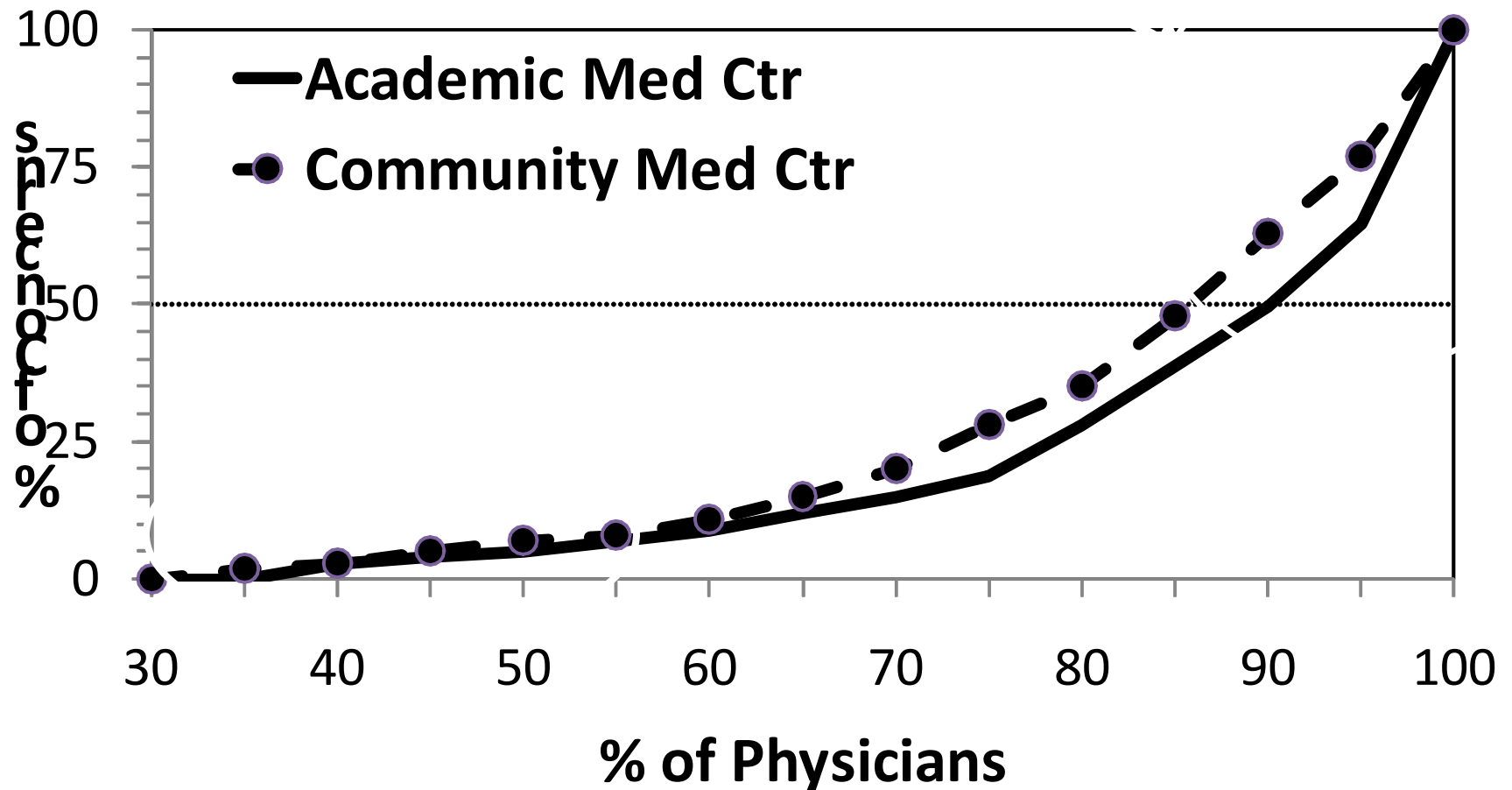
Research Background Summary

- 1-6% hospitalized patients are injured due to negligence
- ~2% of patients injured by negligence file claims
- ~1-3x more patients file without valid claims
- Non-economic factors motivate patients to sue
- Some physicians attract more suits
- High risk for claims today = high risk tomorrow
- Risk can be predicted



- Pt reported: “I had questions about my medical condition and treatment. Dr. OB looked up and asked, ‘Are you illiterate?’ I said, “No.” Dr. OB responded, ‘Oh, I just gave you several pamphlets that explain all of this. Since you didn’t get it, I thought that maybe you were illiterate.’”
- Pt. reported: “Dr. OB said angrily, ‘Can I get a little help from one of your girls?’ I could feel the negativity...made me nervous.”

Academic vs. Community Medical Center 50% of concerns associated with 9-14% of Physicians



Note: 35-50% are associated with NO concerns

Incurred Expense By Risk Category

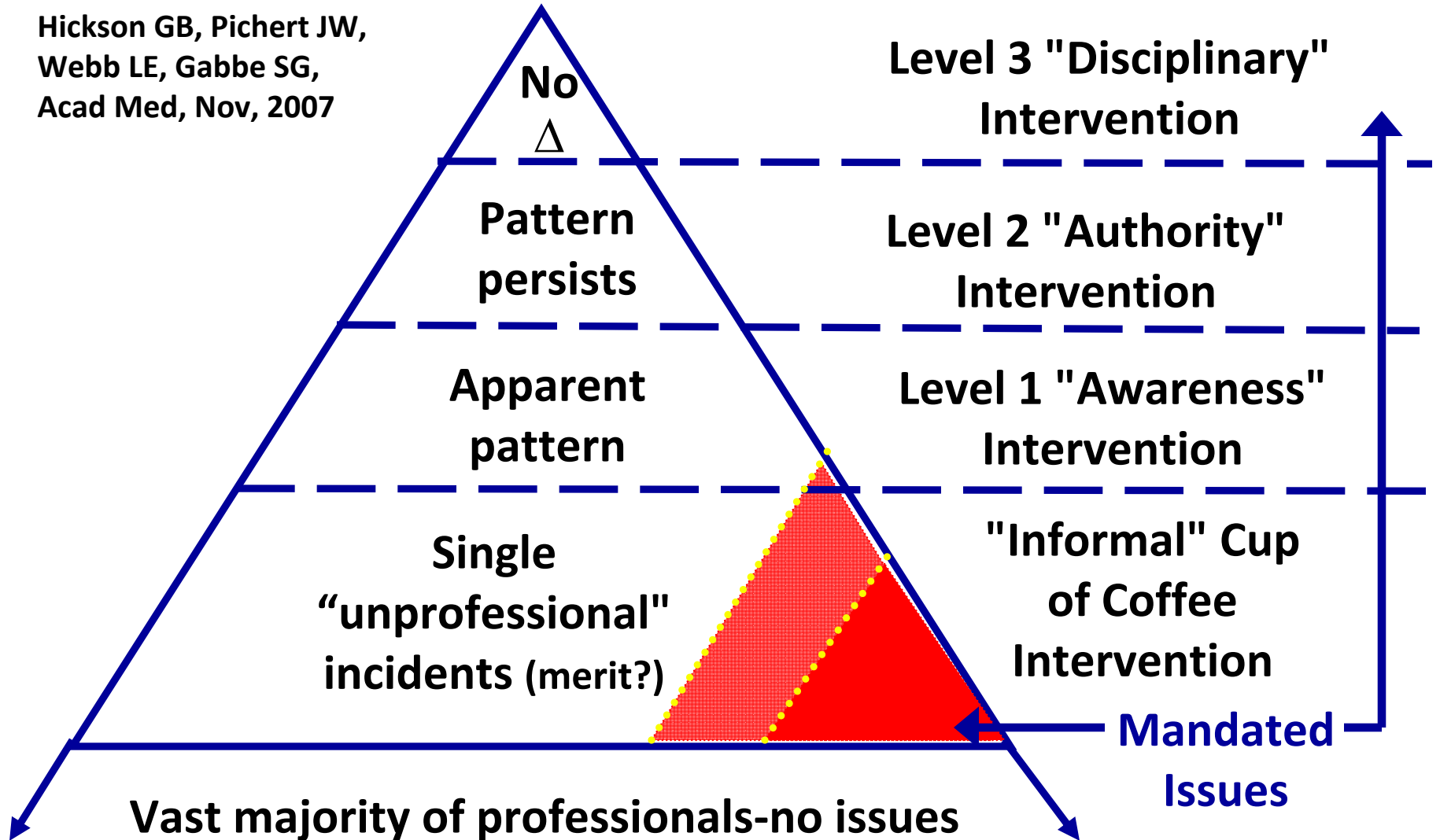
Predicted Risk Category	# (%) Physicians	Relative Expense	% of Total Expense	Score (range)
1 (low)	318 (49)	1	4%	0
2	147 (23)	6	13%	1 - 20
3	76 (12)	4	4%	21 - 40
4	52 (8)	42	29%	41 - 50
5 (high)	51 (8)	73	50%	>50
Total	644 (100)		100%	

* In multiples of lowest risk group

Moore, Pichert, Hickson, Federspiel, Blackford. Vanderbilt Law Review, 2006

Disruptive Behavior Pyramid

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Acad Med, Nov, 2007



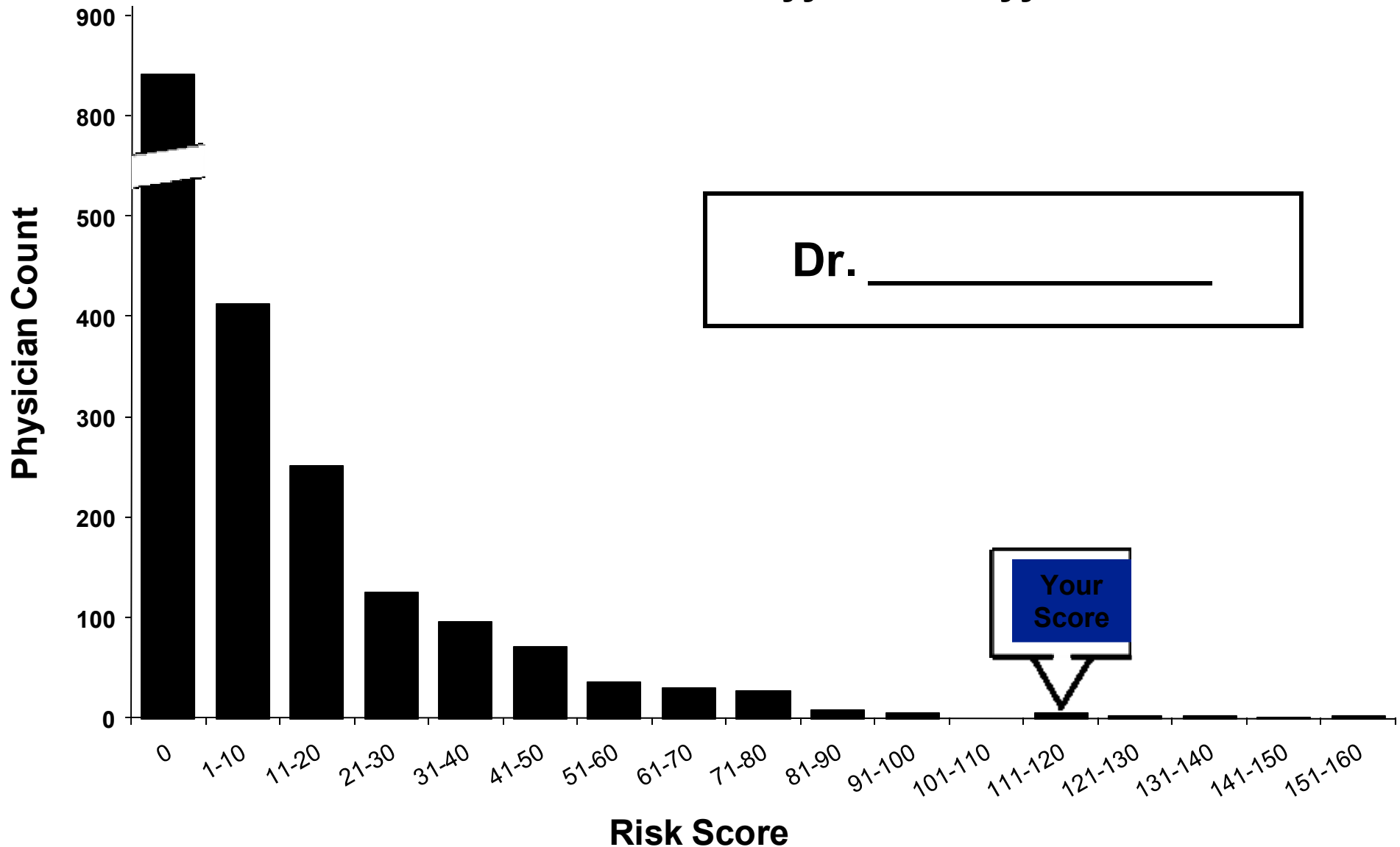
“Messenger” Physician Peers:

- Are committed to confidentiality
- Are respected by colleagues
- Are willing to serve (8 hours of training)
- Have risk scores that are mostly okay (but at several sites physicians intervened upon are messengers)
- Agree to review, then take data to 1-3 physicians at request of local messenger committee chair

(Committee formed under existing QA/Peer review)

Frequency Distribution of Risk Scores: "You are Here"

Audit Period: mm/dd/yy - mm/dd/yy



Distribution is based upon unsolicited patient/family complaints recorded by the Patient Relations representative. The Risk Score reflects the complaints with which each physician was associated. It is based on an algorithm that weights complaints recorded in the past year more heavily than those recorded in prior years.

Confidential:....set forth under "State Peer Review Statutes"

Complaint Type Summary

Dr. _____

Audit Period: Date 1 – Date 2

Complaint Type Categories	Number of Complaints		Distribution of Complaints	
	Your Complaints	Average for Surgery	Your Complaints	Average for Surgery
Care & Treatment	19	4.5	30.2%	39.8%
Communication	15	2.9	23.8%	25.7%
Concern for pt/family	14	1.3	22.2%	11.5%
Access/Availability	9	1.9	14.3%	16.8%
Safety of Environment	0	0.0	0.0%	0.0%
Money/Payment Issues	6	0.7	9.5%	6.2%
Total # of Complaints	63	11.3		

Total Number of Reports

Note: each report may contain multiple complaints

Past 48 months	26	5.9
Past 12 months	6	1.7

Outcomes Summary thru 2007¹

Results for first 336 physicians identified as “high risk”:

Improved	195 (58%)
Unimproved/worse	70 (21%)
Departed the medical group (just prior to <u>or</u> within a year of intervention)	71 (20%)
Total follow-up results	336

¹Pichert JW, Hickson GB, Moore IN: “Using Patient Complaints to Promote Patient Safety.” In: AHRQ (Eds). Advances in Patient Safety: New Directions and Alternative Approaches, 2008.

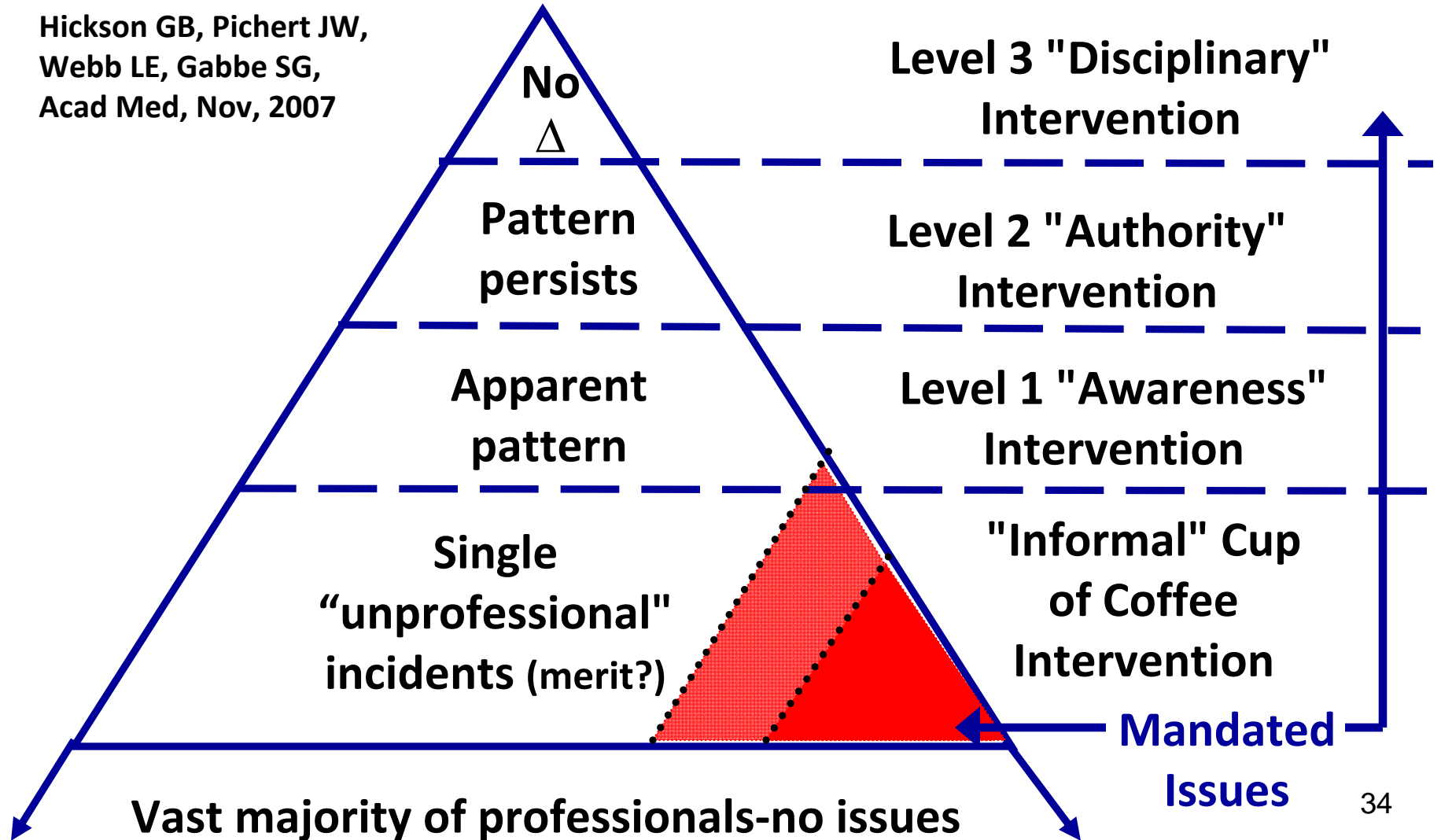


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But what if they don't respond?

Disruptive Behavior Pyramid

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Infrastructure for Addressing Disruptive Behavior (DB)

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The Challenges of Addressing Disruptive Behavior in the Community Hospital Setting

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The Joint Commission (TJC) “Behaviors that undermine a culture of safety”

- All accreditation programs must adopt a code of conduct that defines disruptive, unacceptable behaviors. (EP 4)
- Leaders create and implement a process for managing disruptive and inappropriate behaviors. (EP 5; TJC, Sentinel Event Alert, Issue 40, July 8, 2008)

One Approach

- Administration delegates the preparation of the policy to the Chief of Staff
- Chief of Staff collaborates with the Medical Staff attorney to draft policy
- At the General Staff Meeting, the policy is presented to the medical staff

Problems?

- Physicians voice opposition to the policy
- Several physicians set up an ad-hoc committee to discuss the policy
- Other physicians bring sample policies from organizations such as the American Medical Association
- Some physicians threaten to move their practices

Physicians' Perspective

- Medical staff is self-governing
- Physicians are not the only offenders
- Peer Review
- Competition, economic tool
- Recredentialing process
- Outspoken or unpopular physicians may be perceived as “disruptive”

Protections Offered

- Establish a clear channel to report disruptive behavior
- Objective data collection
- Ensure code of conduct is incorporated into the medical staff rules and bylaws
- Hospital maintains a culture that is supportive and inculcates a positive collaborative culture of safety

Focus on Rehabilitation, Not Discipline

- Adopt a standardized mechanism to investigate and document disruptive behavior
- Establish an informal review process
- Collegial intervention should be established
- Administration provides education and training
- Appropriate referral process for physicians requiring evaluation, diagnosis, and treatment
- Monitoring procedure for the physicians and safety of patients

Dr. Mean

- Dr. Mean is an electrophysiologist who is well trained from a distinguished medical program.
- He moved to the community to establish a private cardiology practice.
- Dr. Mean typically gets irritated if he is paged and the nurses cannot answer all his questions such as the interpretation of the rhythm strips, the list of the patient's medications, and the content of the physicians' progress notes.

Patient Bob

- Patient Bob is a 40 year-old executive with a long history of smoking, hypertension, and obesity.
- He is at risk for heart disease and has been admitted for further cardiac testing.
- Dr. Mean plans to perform an electrophysiology study in the morning if the patient has no further chest pain.

Nurse Sally

- Nurse Sally is a recent graduate from a local nursing school and this is her third month working the night shift.
- Around 9 p.m., patient Bob complains of chest pain.
- Nurse Sally checks Bob's vital signs, listens to his heart, and follows the cardiac protocol by administering nitroglycerin.
- After 10 minutes, patient Bob states that his chest pain has not improved.

Paging Dr. Mean

- Nurse Sally places a call to Dr. Mean's exchange.
- Dr. Mean does not call back within 15 minutes and patient Bob still has chest pain.
- Nurse Sally places a second call to Dr. Mean's exchange.
- Dr. Mean does not call back, so Nurse Sally places a third call to Dr. Mean.

Dr. Mean's Call

- Dr. Mean calls back.
- Nurse Sally begins to present to Dr. Mean the purpose of her call using the SBAR for effective communication per the hospital's standards.
- Dr. Mean interrupts her and demands to know why she did not give patient Bob additional nitroglycerin.
- Before Nurse Sally can answer, Dr. Mean barks the following orders: get a stat EKG, start a nitroglycerin drip, send cardiac enzymes, get a blood gas, then call me with the results.
- He hangs up before Nurse Sally reads back the orders.

Results Return

- Nurse Sally receives the results and places a call back to Dr. Mean.
- Dr. Mean returns the call and asks Nurse Sally to read the results.
- As Nurse Sally starts to read back the results, Dr. Mean interrupts her and asks her to read the blood gas.
- Nurse Sally did not recall that Dr. Mean had ordered the blood gas.

Interaction

- Dr. Mean begins to scream at Nurse Sally, calling her an “idiot” and demanding that he speak to the charge nurse.
- Nurse Sally becomes tearful and gets her charge nurse.
- In the meantime, Dr. Mean hangs up.
- The charge nurse pages Dr. Mean and Dr. Mean again yells, asking why Nurse Sally did not get a blood gas.
- Nurse Sally enters an incident report into the hospital computer system.

Issues Identified from Case Study

- Dr. Mean's interactions
 - Interrupting
 - Yelling, barking orders
- Dr. Mean did not abide by the read-back protocol
- Dr. Mean did not promptly return pages
- Nurse Sally's performance and experience
- Patient Bob's medical care

Consistent, Fair Approach

Regardless of the following:

- Dr. Mean is the Chair of Cardiology
- Dr. Mean is extremely popular with the Administration and facilitates hospital fund-raising
- Dr. Mean is the only electrophysiologist in the community and brings a lot of business to the hospital.
- Dr. Mean plays golf weekly with the President of the Medical Staff

How to Handle

- If this is Dr. Mean's first incident (“informal cup of coffee”).
- If Dr. Mean has a pattern of this behavior and this is his third incident.
- Nurse Sally has performance issues and Dr. Mean was advocating on behalf of the patient.
- Dr. Mean is unpopular with the staff who are eager to submit incident reports but overlook other physicians who act similarly.

Checklist for a Fair Process

- ❑ Is the Code of Conduct part of credentialing process?
- ❑ Did the Code of Conduct define disruptive behavior?
- ❑ Did the physician's orientation include the Code of Conduct?
- ❑ Were the facts in the incident report verified?
- ❑ Was the response to the disruptive behavior prompt and on target?

Process for Incident Involving Disruptive Behavior: Case Presentation

- Incident entered into hospital internal reporting system
- Event is reviewed and investigated
- Involved staff are interviewed and facts verified
- Issues are identified
- Physician is notified
- Determine level of intervention

Intervention

- ❑ “Informal” cup of coffee intervention
- ❑ Level 1: “Awareness” Intervention
- ❑ Level 2: “Authority” Intervention
- ❑ Level 3: “Disciplinary” Intervention

Barriers to the Intervention

- Leadership is not on-board
- The Code of Conduct is not well-drafted
- Definition of “disruptive behavior” is too broad
- Lack of resources to train and rehabilitate
- Insufficient management skills of physician champions
- Physicians fear repercussion, peer review, credentialing file
- Inconsistent approach depending on which physician was involved

Barriers to the Intervention

- No central reporting system
- Time commitment
- Independent medical staff that are not hospital employees
- Physicians provide financial support to the hospital so tendency to ignore certain behaviors.

Tips to Achieve a Successful Disruptive Behavior Approach

- Ensure strong leadership that will apply policies consistently
- Use data to share statistics about the impact of disruptive behavior: patient safety, claims
- Obtain physician input
- Select physician champions
- Implement a simple policy
- Carefully define disruptive behavior

Tips to Achieve a Successful Disruptive Behavior Approach

- Establish a process to report and investigate disruptive behavior allegations
- Incorporate the code of conduct policy into the credentialing & recredentialing process
- Communicate the policy`
- Instill a culture of trust and mentoring
- Educate the employees and medical staff
- Establish an effective intervention program focusing on rehabilitation and training and supported by leadership



Legal and Practical Strategies

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A Legal Perspective

Legal issues to be Addressed and Revolved

- Compliance with Joint Commission and Bylaw Standards
- State Reporting Obligations
- National Practitioner Data Bank Reporting Obligations
- Negligent Credentialing/Malpractice Issues
- HR Employment Issue Impact
- Peer Review/Confidentiality Issues
- After Care Obligations and Considerations
- Responding to Third Party Inquiries

Joint Commission and Bylaw Standards

- Must determine health status of applicants and existing members of the Medical Staff (MF.06.01.05, EPs 2 and 6)
 - Must make inquiry as part of appointment/reappointment process.
 - Bylaws should contain provisions that accomplish the following:
 - Burden of producing any and all information regarding history of disruptive/impaired behavior is on physician.
 - Failure to disclose requested information from whatever source shall result in withdrawal of application from consideration.
 - If information not discovered until after appointment/reappointment has been completed, physician can be terminated – Data Bank reporting implications.

Joint Commission and Bylaw Standards

(cont'd)

- Ongoing obligation to monitor physician conduct and behavior.
- Definition of “professional behavior” and “disruptive behavior” tied to adopted Code of Conduct and/or Disruptive Behavior Policy needs to be included in Bylaws or cross referenced to Policies.
- Physicians should be obligated to disclose any impairment or actions taken at another hospital regarding impaired or disruptive behavior.
- All disruptive behavior needs to be identified and reported via incident report or other method and assessed with direct involvement by and communication with the physician and persons reporting the event.

Joint Commission and Bylaw Standards

(cont'd)

- Any “reasonable suspicion” of impairment also must be reported to Department Chair, CMO, VPMA, President of Medical Staff and CEO.
- Failure of physician to cooperate in review or to submit to assessment/evaluation/fitness for duty review may result in disciplinary action.
- Bylaws should make clear that overall goal of any disruptive behavior/impaired physician policy is to work collaboratively with the physician in order to identify source of issues and to develop a plan to help the physician achieve compliance with standards and policies, in order to remain on Medical Staff.

Joint Commission and Bylaw Standards

(cont'd)

- Corrective action should be the last option considered after other remedial measures have failed unless action needs to be taken immediately to protect patients, employees and the general public.
- Joint Commission accredited hospitals must have adopted a Disruptive Behavior Policy by January, 2009 for all hospital personnel – not just physicians.
 - Issues and Complications:
 - Some hospitals have adopted a Code of Conduct applicable to physicians, a Disruptive Behavior Policy applicable to all, a Physician Wellness Committee, an HR Policy applicable to employed physicians as well as a standard for recommending corrective action.

Joint Commission and Bylaw Standards

(cont'd)

- A review of these different policies often times reveals conflicting definitions of what is described as “unprofessional” or “disruptive behavior” or “impaired conduct”.
- The result can be confusion about what pathway to follow and possible challenge by physician if corrective action is taken in lieu of progressive discipline set forth in Code of Conduct or Disruptive Behavior Policy.
- Policies need to be reviewed and possibly consolidated and behavior which triggers application of resulting policies or Physician Wellness Committee involvement needs to be made uniform.

Joint Commission and Bylaw Standards

(cont'd)

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

Data Bank and State Reporting Requirements

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

Data Bank and State Reporting Requirements (cont'd)

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

Data Bank and State Reporting Requirements (cont'd)

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

Negligent Credentialing/Malpractice Issues

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

Confidentiality Issues

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

Confidentiality Issues (cont'd)

- Once reported to a PSO, it cannot be used for disciplinary purposes against the physician meaning it cannot be relied on if seeking to terminate or suspend the physician for all or some of his or her privileges.
 - There is an exception which would allow hospital to remove information before it is reported to PSO so that it could be used for disciplinary purposes but this action could undermine “just culture” goal of trying to convince physician to acknowledge rather than deny behavioral problems.
 - Must remember that if protected under state and/or PSO confidentiality and privilege protections, hospital cannot introduce information to assert a defense in corporate negligence or other liability action (Frigo v. Silver Cross Hospital).

HR Employment Issues

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

HR Employment Issues (cont'd)

- Although these disparate and conflicting standards may be legally enforceable under contract law but can result in claim that two standards of care or conduct are permitted. If lesser standard applied to independents, who otherwise might have been disciplined or terminated if employed, a patient who is impaired by a disruptive/impaired independent physician would have stronger grounds to bring corporate negligence or similar theory against hospital.
- Terminated employed physicians seldom get same hearing rights as independents but also are rarely reported even though hospital is required to do so under Data Bank requirements.

HR Employment Issues (cont'd)

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

After Care Issues

- Physicians whose disruptive behavior, whether the result of some form of impairment or not, oftentimes are required to participate in some type of educational or rehab program as a condition of maintaining privileges.
- Terms of program can be imposed by the program itself, i.e., Hazelden or Illinois Health Professionals Program, and/or the hospital through its Physician Wellness Committee.

After Care Issues (cont'd)

- It is imperative that the hospital monitor compliance with all elements of the program or Well-Being Agreement.
- Continued membership and privileges should be generally made contingent on continued compliance with the program. Should probably also consider monitoring, or proctoring and/or concurrent review of cases to make sure there are no new or continuing problems as well as to enforce strict internal incident reporting requirements about behavior.

After Care Issues (cont'd)

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

Responses to Third Party Inquiries

- At some point in time, hospital is going to receive a third party inquiry about the physician as part of another appointment, reappointment or employment decision by another facility.
- Hospital needs to decide how it is going to respond, if at. The circumstances might dictate different responses, i.e., physician resigns before disruptive or impaired behavior is confirmed; physician resigns in middle of investigation; physician resigns after findings confirmed; physician terminated for failure to cooperate or to comply with after care plan; physician is successfully complying with program but is seeking appointment/reappointment elsewhere.

Responses to Third Party Inquiries

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

Responses to Third Party Inquiries

(cont'd)

- Although no duty to respond, if one is provided, hospital cannot purposefully nor negligently misrepresent the circumstances of physician's status or mislead the third party (See attached advisory letter).
- Steps to consider if responding
 - Make sure that physician signs separate waiver of liability form – this is standard practice.

Responses to Third Party Inquiries

(cont'd)

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

Responses to Third Party Inquiries

(cont'd)

- Hospital should argue that any response to a third party inquiry is a privileged peer review communication and therefore if sued by the physician, response will be deemed inadmissible. See Soni v. Elmhurst Memorial Hospital
- Additional argument to utilize is that most hospitals also have an immunity clause in Medical Staff Bylaws for peer review decisions and communications which applies to this situation.