Dealing with Problematic Doctors: From Behavioral Challenges to Competency Concerns

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Who are “challenged” colleagues?

- Those who engage in unprofessional conduct
- Those who display clinical deficiencies
- Those who engage in substance abuse
- Those who have health issues which impact patient safety
Why focus on unprofessional conduct?

Because it undermines:

• Quality Care
• Patient Safety
• Morale
• Clinical & Administrative Operations
• Professionalism
• Public Confidence & Respect
Why focus on unprofessional conduct?

• Because it creates Liability
• To meet new regulatory requirements
• To adequately differentiate the legitimate expression of valid quality concerns
Britannia between Scylla & Charybdis.

or The Vessel of the Constitution, stared chair of the Rock of Democracy, and the Whirlpool of Arbitrary Power.
Scylla & Charybdis

Corporate Negligent Lawsuits
- Negligent Credentialing
- Negligent Peer Review

Suits from the Federal Government
- False Claims Act
- Fraud and Abuse/Stark

Legal action by staff: hostile workplace/sexual harassment

Lawsuits from Physicians
- Breach of contract
- Restraint of trade
- Interference with business opportunity
- Discrimination
- Defamation
- Injunctions and restraining orders
And let’s not forget the Joint Commission!

- New standard on disruptive physician conduct
- The ongoing challenge of FPPE/OPPE
Two Types of Problematic Physicians

- Quality Concerns
- Conduct Concerns

Which is more prevalent?
Have You Experienced Legal Challenges from Physicians?
Disruptive Physicians:
Unprofessional conduct can manifest as:

• Disrespectful, profane, demeaning, or rude language
• Sexually inappropriate speech or behavior
• Intimidation
• Racial/Ethnic innuendo or insults
• Throwing tirades and/or objects
• Criticizing other caregivers in front of patients or other staff
• Comments that undermine a patient’s trust in other caregivers or the hospital
• Repeated, intentional non-compliance with organization rules and policies
• Deliberate interference with the smooth functioning of hospital or medical staff operations
• Inappropriate entries in the medical record
• Unethical/Dishonest behavior
• Repeated lack of response to calls
• Difficulty working collaboratively
• Inappropriate arguments with pts, family, staff, MDs
• And more...
BADMIND
Doctor-Nurse Behavior Problems Impact Patient Care

**2. Does your health care organization ever experience behavior problems with doctors and nurses?**

<table>
<thead>
<tr>
<th>Response</th>
<th>%</th>
<th>Count</th>
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<tr>
<td>Yes</td>
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<td>2,088</td>
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<tr>
<td>No</td>
<td>2.6%</td>
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answered question 2,143
skipped question 14
A Sure Way to Make a Scarce Resource Scarcer

• 64% of nurses report some form of verbal abuse from a physician at least once every 2-3 months

• 23% of nurses reported at least one instance of physical threat from a physician (most commonly a thrown object)

• Nurses rate disruptive physician behavior as the single most important contributing factor to job morale & satisfaction

• Studies suggest more than 18% of nurse turnover is directly attributed to verbal abuse
Why are we “disruptive”?

• Substance abuse accounts for less than 10% of physician behavior problems

• Less than 5% of the physician population engages in disruptive conduct

• Few have a major psychiatric problem

• Maybe it’s because we always had ‘disruptive’ physicians in our midst and no one has done anything about it - leading to a culture of inappropriate tolerance
Joint Commission Sentinel Event Alert

New Leadership Standards: Effective January 1, 2009

- Must have a “code of conduct that defines acceptable and disruptive and inappropriate behaviors”
- Recommends utilization of reporting systems and physician education & training programs
What Should Be in a Policy?

- Definitions of unprofessional conduct and examples: general & specific
- Requirements for staff education & training
- Process for confidential reporting of incidents
- Process for evaluation of incidents
- Progressive steps for intervention
Caveat: Prevention is Less Painful than Cure

• Good credentialing can identify many physicians with conduct problems prior to a grant of membership
Case Scenario
Case Example: Conduct Concerns

Gordon v. Lewistown Hospital

(Lessons from Judge Rambo)
What kinds of Interventions?

Interventions should be early (timely) and often

Successive interventions should be progressive - but determined by the risks posed to patients

- Remind practitioner of your policy (form letter)
- Discussion of behavior with influential colleague/leader/ board member
- Formal letter
- Appearance before MEC
Progressive Intervention (continued)

- Formal evaluation
- Letter of reprimand
- Disciplinary suspension/conditional reappointment
- Requirement for participation in an appropriate behavioral management program
- Loss of privileges/membership
What does the case law tell us?

Whistle blowing does not excuse disruptive behavior.

- Wieters v. Roper Hospital (No. 01-2433. 4th Circuit, Feb. 27, 2003)
Dealing with Unprofessional Conduct:
A GUIDE FOR PHYSICIAN LEADERS & HEALTHCARE ORGANIZATIONS
A Medical Leadership Institute White Paper • Winter 2009
Physicians reluctant to report impaired colleagues, study says

More than a third of doctors surveyed said it is not their responsibility to report all physicians with mental health or substance abuse problems.

Barriers to whistle-blowing

Of doctors who didn't report:

• 19% thought someone else was taking care of the problem.
• 15% believed nothing would happen as a result of the report.
• 12% feared retribution.
• 10% believed it was not their responsibility.
• 9% believed the person would be excessively punished.
• 8% did not know how to report.
• 8% believed it easily could happen to them.

Note: respondents could answer "yes" to more than one reason.

Source: “Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues," *Journal of the American Medical Association*, July 14 ([jama.ama-assn.org/cgi/content/abstract/304/2/187/](jama.ama-assn.org/cgi/content/abstract/304/2/187/))
Problematic Physicians: Those with Quality Concerns

Frank started to get a funny feeling that his doctor was a quack.
Is Hospital Peer Review Adequate Protection for Patients?

- How would you know?
Characteristics of Contemporary Peer Review

- Less reliance on chart review than in past
- Greater reliance on data review
- Performance indicators are reviewed regularly
- Peer review committees are interdisciplinary - less department based
- Physician feedback is routine
- External peer review judiciously utilized
Getting into Trouble with Corrective Action:

Territory fraught with landmines
Case Study: Discussion

The Quality Department reports to the peer review committee 2 cases of Dr. Smith's in which a major artery was nicked during laparoscopic surgery. The committee instructs the Quality Department to pull a sample of thirty charts for cases in the past year where Dr. Smith performed laparoscopic surgery. While undertaking this review Dr. Smith resigns from the medical staff and consolidates his practice at the hospital across town where he also has active privileges.

The chair of the peer review committee calls the medical staff office to request that a report be filed with the National Practitioner Data Bank.
When Is An Investigation Warranted?

- Who initiates? Based on what criteria?
- Who undertakes the investigation?
- When is it concluded?
- What decisions must follow?
Report Properly

Never file a report unless required

- Know your state rules
- Know NPDB requirements
  - Suspensions that last *more* than 30 days or
  - Within 15 days of a *final* adverse professional action

Never fill out reporting forms without careful consideration

- NPDB Reports: make liberal use of the “other” code
Dr. Trunkle is a radiologist on staff known for the high volume of studies he reads. Lately he has been particularly busy because of a resignation of two radiologists in his department. Because of two serious misreads the MEC has been asked by the peer review committee to suspend Dr. Trunkle’s privileges.

What should the MEC do?
Corrective Action: A Dangerous Course of Action

- Have we exhausted other options?
- Have we “investigated”?  
- Is it necessary to protect patients, staff, or the institution?
- Have we addressed real, potential, or perceived conflicts of interest/biases
- Are we prepared to do it right?
Collegial Peer Review (Performance Improvement) Tools

- Periodic performance feedback reports;
- Mentoring from clinical colleagues;
- Verbal feedback from peers, including medical staff leaders;
- Proctoring (concurrent, retrospective, and prospective);
- Traditional peer review - i.e. chart review
- External peer review;
- Morbidity & Mortality (M&M) and Clinical Pathology Conferences
- FPPE and OPPE
- Root cause analyses and FMEAs (Failure Modes & Effects Analysis);
- Written communications from physician/hospital leaders, including:
  - letters articulating and reinforcing performance expectations and deviations from such expectations;
  - letters of reprimand;
  - letters of warning regarding possible formal consequences for clinical or professional conduct.
To Suspend or Not to Suspend?

That is the question!
Suspensions: A Small Matter of Language

- Summary Suspension
- Abeyances & “Voluntary” Suspension
- Precautionary Suspensions
- Disciplinary Suspensions- Disciplinary “Time Outs”
- “Mandatory” Leave of Absences

- Documentation: Watch Your Language (echo HCQIA and your bylaws)
Hot Spots: Denials, Suspensions, Reporting, Due Process

- Never “deny” unnecessarily
  - Only for incompetence & unprofessional conduct
  - Have criteria based privileging forms
    - Part of a periodic Board credentialing audit

- Watch out for exclusive contracts, closed services

- Know how you will address employed physicians

- Penny Wise- Pound Foolish
  - Almost never forgo External Peer Review

- Offer to Tango
  - Mediation, Agreements and Settlements
  - Use outside resources for remediation (e.g. Lifeguard program)
Bylaws Language

- Have the right “releases” and “waivers”
- Address “good standing”
- Use clear language concerning Investigations
- Give the right amount of due process: but not more than necessary
Clarifying When A Hearing Will Not Be Offered

- Issuance of a letter of guidance, warning, or reprimand.
- Imposition of a requirement for proctoring with no restriction on privileges.
- Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege.
- Requirement to appear for a special meeting under the provisions of these bylaws.
- Conducting an investigation into any matter or the appointment of an ad hoc investigation committee.
- Automatic relinquishment or voluntary resignation of appointment or privileges.
- Imposition of a suspension that does not exceed 14 calendar days.
- Denial of a request for leave of absence, or for an extension of a leave.
- Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership.
• Determination that an application will not be processed due to misstatement or omission.

• Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement.

• Determination that an application is incomplete or untimely.

• Termination of any contract with or employment by hospital.

• Any recommendation voluntarily accepted by the member.

• Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period.
• Change in assigned staff category.

• Removal or limitation of emergency department call obligations.

• Any requirement to complete an educational assessment.

• Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws.

• Grant of conditional appointment or appointment for a limited duration.

• Appointment or reappointment for a duration of less than 24 months.
Bylaws Language

- Have the right “releases” and “waivers”
- Address “good standing”
- Use clear language concerning Investigations
- Give the right amount of due process: but not more than necessary
- Watch language regarding ‘Suspensions’
- Address Fair Hearings adequately
Have Good Policies

- Policy on Collegial Interventions
- Policies on Information Sharing (within the health system & with outside parties)
- Policies on Confidentiality
- Code of Conduct Policy
- “Impaired” Physician Policy
Fair Hearings & Appeals

- Have good policies
- Provide close counsel
- Use a presiding or hearing officer
- Don’t overly rely on the determinations of others
- Keep appeals simple & focused on process review
How are changes in the organization of the hospital and physician community affecting the management of problem physicians?
Physician Leadership Development: The Key to Success
The Bottom Line:
Do the Right Thing

And when you do, do it right.