

## Disruptive Behavior by Physicians in Hospitals: A Threat to Patient Safety?

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The creation of a medical care culture focused on patient safety continues to be a work in progress. We now have the “better manners by mandate”<sup>1</sup> proposal by the Joint Commission<sup>2</sup> to deal with the problem of bad behavior by doctors and other healthcare personnel in the hospital setting. The dismissive, condescending, drug-addled behavior of television physician icons such as Hugh Laurie on the popular television show *House*<sup>3</sup> may work as a model for appropriate physician role models in prime time, but health care regulators are no longer amused. Why has the issue of physician behavior in hospitals become such a flashpoint issue? Will the proposal by the Joint Commission really do anything about it, and more importantly will the treatment be any better than the disease?

### The Problem Defined

The issue of disruptive behavior in the patient care setting - whether by physicians, nurses, pharmacists, or other hospital personnel - has become an important problem because the safety of patients in hospitals is now a highly publicized problem. The Institute of Medicine (IOM) *Report on Patient Safety*,<sup>4</sup> which repetitively emphasized what dangerous places hospitals can be for patients, also noted that it is not just mistakes by physicians which can result in patient deaths. The growing emphasis on prevention of mistakes assumes as a given, as the IOM does, that the “culture of intimidation”<sup>5</sup> which accompanies disruptive behavior by physicians and other healthcare personnel implicitly contributes to mistakes.

The American College of Surgeons has pointed out that up to forty percent of clinicians have kept quiet or stood by passively during disruptive events occurring during patient care rather than confront a known intimidator.<sup>6</sup> Even if there is little evidence to prove that disruptive behavior is directly linked to adverse patient outcomes, there is good

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<sup>1</sup> Theo Francis, *Better Hospital Manners by Mandate*, HEALTH BLOG, THE WALL STREET JOURNAL, July 9, 2008, available at <http://www.blogs.wsj.com/health/2008/07/09-better-hospital-manners-by-mandate/print/> (last accessed July 10, 2008).

<sup>2</sup> THE JOINT COMMISSION, *The Joint Commission News Releases: Stop Bad Behavior among Health Care Professionals*, July 9, 2008, available at [http://www.jointcommission.org/NewsRoom/NewsReleases/nr\\_07\\_09\\_08.htm?print=yes](http://www.jointcommission.org/NewsRoom/NewsReleases/nr_07_09_08.htm?print=yes) (last accessed September 14, 2008).

<sup>3</sup> Dr. Gregory House “is an irreverent, controversial doctor who trusts no one, least of all his patients...and is devoid of bedside manner and wouldn’t even talk to his patients if he could get away with it” according to the promotion on the television show’s website, available at <http://www.tv.com/house/show/22374/summary.html> (last accessed September 14, 2008).

<sup>4</sup> INSTITUTE OF MEDICINE, *TO ERR IS HUMAN. BUILDING A SAFER HEALTH SYSTEM* (2000). The IOM concluded that medical errors, especially hospital-acquired conditions, were responsible for up to 98,000 deaths annually in the U.S.

<sup>5</sup> Joel Aleccia, *Hospital bullies take a toll on patient safety*, MSNBC News July 9, 2008, available at <http://www.msnbc.msn.com/id/25594124/print/1/displaymode/1098/> (last accessed July 9, 2008).

<sup>6</sup> BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS, *A look at The Joint Commission. Alert aims to stop bad behavior among health care professionals*, October 2008.

evidence to suggest that nurses believe that it is; this alone should give health law policy makers pause. The Joint Commission noted<sup>7</sup> that up to seventy percent of nurses believed that there was a direct link between disruptive behavior by physicians and adverse clinical outcomes. Even more significant was the finding that up to twenty five percent of nurses believed that there was a direct relationship between intimidating physician behavior and patient mortality.<sup>8</sup>

Although hard data to prove this last point are lacking, patient safety concerns have clearly shifted the attitude by the medical profession itself from one of underreporting disruptive behavior to attempting to address what has been an elusive and frustrating problem for hospital administrators and personnel. Absent serious engagement of the issue of physician conduct by the medical profession itself, it is doubtful that any recommendation even by organizations as important as the Joint Commission would have any significant impact. The Joint Commission outlined ten elements of performance within the applicable Joint Commission Standards<sup>9</sup> which focus on the importance of hospital organization leadership in bridging the gap between established patient safety initiatives and changing physician behaviors that undermine the culture of safety.

Existing Joint Commission requirements already address the general issue of disruptive and inappropriate conduct. The current alert calls on all hospitals, nursing homes, home health agencies, laboratories, ambulatory care facilities and behavioral health care facilities to have a code of conduct that defines disruptive/unacceptable behaviors and to have a process for internally managing such behavior in place by January 1, 2009.<sup>10</sup> The new standards would obviously be implemented on an institution by institution basis. The new recommendations include eleven specific suggested actions,<sup>11</sup> such as providing skills-based training for medical personnel and holding those in medical supervisory positions accountable for modeling desirable behaviors.

The American Medical Association Code of Medical Ethics also specifically addresses the topic “Physicians with Disruptive Behavior,”<sup>12</sup> though the position statement concerns only the conduct of individual physicians in the hospital setting. “Disruptive behavior” is defined as “personal conduct, whether verbal or physical, that negatively affects or potentially may negatively affect patient care.” Although this definition appears expansive, the AMA does attempt to exclude application of this label to “criticism that is offered in good faith with the aim of improving patient care.”<sup>13</sup> The AMA statement also

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<sup>7</sup> THE JOINT COMMISSION, *Behaviors that Undermine a Culture of Safety. Applicable Joint Commission Standards*, July 9, 2008, available at <http://www.jointcommission.org/NewsRoom/PressKits/Behaviors+that+Undermine+a+Culture+of+Safety> (last accessed October 10, 2008).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> THE JOINT COMMISSION, *supra* note 2.

<sup>12</sup> American Medical Association, Code of Medical Ethics, E-9045 Physicians with Disruptive Behavior, available at [http://www.ama-assn.org/apps/pf\\_new/pf\\_online?f\\_n=browse&doc=policyfiles/HnE/E.904](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E.904) (last accessed August 5, 2008).

<sup>13</sup> *Id.*

goes out of its way to emphasize that the label is more aptly applied to behavior that is repetitive rather than just an isolated incident and notes that physicians must be provided both an appropriate forum to rebut a charge of disruptive behavior and a mechanism to rehabilitate behavior deemed disruptive.<sup>14</sup>

Missing from the AMA statement, or the Joint Commission recommendation, is a working definition of what specifically constitutes disruptive behavior. As such, the Joint Commission recommendation is really a call for every hospital and academic medical center to have its own definition of what constitutes unacceptable behavior. The “standard” for acceptable behavior is thus a subjective, not an objective, one and will undoubtedly vary in different parts of the U.S. and likely will vary from hospital to hospital within the same geographical area. Physicians will need to be aware of the lack of a uniform standard defining unacceptable behavior. Also absent from either organization is a specific recommendation as to how hospitals in general should deal with this issue. Thus, there is no “standard” procedure for handling disruptive behavior per se, and no firm guidance to differentiate between righteous indignation on the part of a frustrated physician and the rude, disruptive behavior which potentially threatens patient safety and about which all parties are justifiably concerned.

### Potential Problems

Even if these legitimate limitations were addressed and substantive, specific guidelines with real teeth were proposed and passed, no real attention has been paid to the way in which a charge of disruptive behavior could be used by those in positions of power in a hospital to weed out physicians felt to represent an economic threat to more favored medical staff (a phenomenon known as “economic credentialing”)<sup>15</sup> or who were perceived to be whistleblowers, pointing out negligent or substandard medical practice by either the hospital or other members of its physician staff. This is no small consideration, particularly in small community hospitals where long-standing referral and practice patterns may be disrupted by new medical staff members, particularly if the new medical staff is younger, better trained, and offers more cutting edge medical or surgical practice previously not available and which constitutes an economic threat to other physicians.

Perusal of the list of grounds for license denial or revocation by the Texas Medical Board lists numerous grounds for license denial or disciplinary action, including if the physician “behaves in an abusive or assaultive manner towards a patient or the patient’s family or representatives that interferes with patient care or could be reasonably expected to adversely impact the quality of care rendered to a patient.”<sup>16</sup> The wording of this may be too broad: a physician could be removed from a hospital staff position simply because he or she received a warning letter for an infraction of hospital rules if it were determined that the conduct were “unprofessional.” In general, courts do not like to interfere with the internal rules hospitals have for policing their medical staff,<sup>17</sup> and may prefer that

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<sup>14</sup> *Id.*

<sup>15</sup> David C. Pate, *REGULATION OF HEALTH CARE PROFESSIONALS*, Carolina Academic Press (2002).

<sup>16</sup> MEDICAL PRACTICE ACT (MPA) § 164.053; 22 TEX. ADMIN. CODE § 190.8(2).

<sup>17</sup> *Austin v. American Association of Neurological Surgeons*, 253 F.3d 967 (7<sup>th</sup> Cir. 2001).

hospitals settle these matters internally with mechanisms designed to allow physicians to tell their side of the story. Although the Joint Commission requires that all hospitals have procedural rules in place to ensure that physicians charged with being “disruptive” will be able to tell their side of the story, there is no question that unpopular or outspoken members of a medical staff run a real risk of significant disciplinary action if charges of disruptive behavior are affirmed. The remedies available to physicians found disruptive by a hospital medical staff disciplinary committee are also defined by individual hospital staff rules which vary from institution to institution. In the long run these internal procedural protections offered to physicians accused of being disruptive may be limited value if the only “appeal” of the hospital decision is suing in a court generally reluctant to interfere.

### Conclusion

Patient safety concerns are a major focus of health care reform, as they should be. Any legitimate effort to improve the hospital environment and lessen the risk of patient harm is difficult to argue against, particularly if both individual state medical boards and the Joint Commission are determined to change a “culture of intimidation.”<sup>18</sup> State medical boards are under increasing public pressure to “do something” about rogue doctors, disruptive physicians, patient safety, and the conduct of the medical profession in general, and “better manners by mandate” is likely another necessary step in efforts to improve patient safety in any medical care setting but particularly in hospitals. Given the larger issues at stake, and limited legal options to fight disruptive behavior decisions, all health care providers would be wise to pay serious attention to their perceived behavior in the hospital setting.

*Health Law Perspectives* (October 2008), available at:  
<http://www.law.uh.edu/healthlaw/perspectives/homepage.asp>

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<sup>18</sup> THE JOINT COMMISSION, *supra* note 2.