Legal Issues Related to Disruptive Behavior
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THE JOINT COMMISSION

On July 9, 2008 the Joint Commission issued a "Sentinel Event Alert" discussing new Leadership Standard LD.03.01.01 and its related Elements of Performance, EP4 and EP5, which became effective January 1, 2009. That Standard required hospital leaders adopt a code of conduct defining disruptive behavior and establishing a process for managing such behavior. The Standard did not itself defined disruptive behavior, but the accompanying Sentinel Event Alert stated that such behaviors included ". . . overt acts such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities . . . . Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients."

The Elements of Performance related to the new Leadership Standard mandate that:

> "EP4: Leaders develop a code of conduct that defines acceptable, disruptive and inappropriate behaviors.
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> EP5: Leaders create and implement a process for managing disruptive and inappropriate behaviors."

Effective July 1, 2012 the Joint Commission revised these Elements of Performance to delete reference to the phrase "disruptive and inappropriate behaviors." The Joint Commission explained that the term "disruptive behavior" can be considered ambiguous and noted that physicians who express strong advocacy for improvements in patient care can be inappropriately characterized as disruptive. Accordingly, the Joint Commission adopted the phrase "behaviors that undermine a culture of safety" in place of "disruptive behavior."

CALIFORNIA LAW

The Joint Commission requirements obligated hospitals to establish a code of conduct for all persons working in the hospital. In California, the process of adopting standards to govern the behavior of Medical Staff members is the responsibility of the Medical Staff, which is independently responsible "for policing its member physicians" (Health & Safety Code Section 1250(a); 22 CCR Section 70701(A)(1)(F); Business And Professions Code Section 2282.5. The Joint Commission's Sentinel Alert affirms the role of the Medical Staff, stating that Medical Staff Bylaws regarding physician behavior should be complementary and supportive of policies that are in place for the organization of the non-physician staff. The Sentinel Alert further states that Medical Staff credentialing standards requiring "interpersonal and communication skills" and "professionalism" be part of the privileging and credentialing process (2011 Joint Commission Standards, Introduction to Standard MS 06.01.03.

The California courts have made clear that disciplinary action predicated upon disruptive behavior may not be "substantively irrational or otherwise unreasonably susceptible to arbitrary

or discriminatory application" (*Miller v. Eisenhower Medical Center*, 27 Cal.3d 614 (1980)). For that reason, the California Supreme Court noted in *Miller* that physicians may only be disciplined for disruptive or inappropriate behavior "if there is a sufficient nexus to patient care" (*Id* at 622).

The *Miller* court found that a bylaw requirement that physicians demonstrate an "ability to work with others" was, of itself, so vague as to be subject to arbitrary and irrational application and that to guard against such inappropriate application the standard must demand a showing that the applicant's inability to work with others is such as to present "a real and substantial danger that patients treated by [the physician] might receive other than appropriate care." The court further noted that physician conduct considered controversial, outspoken and even personally offensive to some hospital colleagues might not have an adverse impact upon the delivery of care.

Later decisions have clarified that finding a nexus between disciplinary action for disruptive behavior and adverse impact on patient care does not require a showing of a particular harm to a patient and that a reasonable assessment of the potential for such harm in the future was sufficient. (*Marmion v. Mercy Hospital and Medical Center*, 145 Cal.App3d 72 (1983).

A California federal, court dealing with a claim of denial of federal due process related to disciplinary action taken at a district hospital, applied a similar standard when it noted that "when the individuals who have been on the receiving end . . . determine . . . that rudeness and/or disruptive behavior has reached a level that potentially compromises care of any patient, that conclusion is generally not susceptible to argument to the contrary." (*Jablonsky v. Sierra Kings Healthcare District*, 790 F.2d 1148 (Eastern District of California 2011).

THE DUTY TO ACT

Once a Medical Staff has adopted standards and policies for defining inappropriate behavior, it is obligated to enforce those standards and implement those policies. Consistent with Joint Commission Standard MS11.01.01, requiring the Medical Staff to implement a process to identify and manage matters of individual health, separate and apart from actions taken for disciplinary purposes, the process for managing disruptive behavior should appropriately include an assessment of whether or not the behavior is reflective of health issues susceptible to rehabilitation. If so, the process for handling the behavior should, in the first instance, attempt to facilitate rehabilitation rather than discipline.

However, whether through rehabilitation efforts or disciplinary action, the Medical Staff must not ignore disruptive behavior. California law is clear that if the Medical Staff of a hospital fails to take action against a physician who "provides substandard care or who engages in professional misconduct" the governing body of the hospital acts as a failsafe to ensure that the practitioner is removed from the hospital Staff (*El-Attar v. Hollywood Presbyterian Medical Center*, 56 Cal.4th 976, 993 (2013). It is well recognized that the a Medical Staff and a hospital's failure to ensure the competency of its Medical Staff may result in liability to patients (*Hongsathavij v. Queen of Angels Medical Center*, 62 Cal.App.4th 1123 (1998); to other members of the Medical

Staff (*Samuel v. Providence Health Care System – Southern California*, unpublished opinion 2013 WL 6634119, (December 17, 2013)), to non-physician staff members such as nurses (*Fisher v. San Pedro Peninsula Hospital*, 262 Cal.Rptr. 842 (1990)), and, perhaps, even to the family of the physician whose conduct manifests a need for rehabilitation, if rehabilitation is not provided.

THE IMPACT OF EMPLOYMENT STATUTES

Hospitals, as employers of nursing and support staff, have an obligation to ensure that those employees are provided with a safe workplace, including an environment free from harassment. Under state law, it is unlawful for an employer to harass an employee, or to allow harassment to continue if the employer knew or should have known of harassing conduct and failed to take "immediate and appropriate corrective action." (Govt. Code section 12940, subd. (j)(1).) In a practical sense, this means that the Human Resources Department of the hospital must promptly investigate the matter and take such remedial actions as are available to the hospital. Of course, while the hospital may be able to place an employee on paid leave and potentially diffuse a problem directed toward that individual employee, that strategy is not available when disruptive behavior on the part of the physician adversely affects an entire area of the hospital's operations.

Thus, it becomes obvious that the Human Resources Department of the hospital and the Medical Staff must work promptly and cooperatively to investigate matters of mutual concern created by the disruptive behavior. Such cooperative conduct presents its own set of challenges, including the maintenance of the protection of peer-review information pursuant to Evidence Code section 1157.

It may well be that the only mechanism available to promptly insulate hospital employees from an unsafe work environment created by physician conduct is the remedy of summary suspension. It should be recognized that the desire to be self-governing may create some pushback on the part of the Medical Staff in those instances in which hospital administration is demanding summary suspension of a physician in order to protect hospital employees. Trying to work through such a conflict in the midst of dealing with the crisis created by a disruptive physician is extremely difficult. For this reason alone, a written policy adopted by both the Medical Staff and Hospital Administration, regarding the way in which to cooperatively investigate such matters and assure a safe work environment is of extreme importance. In any such policy, consideration must be given to the maintenance of peer review confidentiality and non-discoverability under Evidence Code section 1157.

THE IMPACT OF THE WHISTLEBLOWER STATUTES

The courts have long recognized the value of physician advocacy as a part of the quality assurance process. As noted in *Rosner v. Eden Township Hospital*, 58 Cal.2d. 592 (1962) "the goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel that treatment of patients is improper or that negligent hospital

practices are being followed." It was out of such recognition that California's whistleblower statutes protecting physicians (Business & Professions Code section 2056 and Health & Safety Code section 1278.5) were enacted to prevent retaliation against physicians who advocate for medically appropriate care.

Practical experience has shown that a physician charged with disruptive and inappropriate conduct is highly likely to claim that his or her conduct was not disruptive but rather constituted "advocacy" and that any effort to discipline the physician constitutes retaliation.

In light of the California Supreme Court in *Fahlen v. Sutter Central Valley Hospitals*, 58 Cal.4th 655 (2014), which determined that a physician did not need to exhaust all available judicial remedies to overturn disciplinary action before pursuing a whistleblower claim pursuant to Health & Safety Code section 1278.5, the prospect clearly exists that the Medical Staff and hospital attempting to respond to a physician's disruptive and inappropriate conduct may have to contend with the physician's legal action asserting retaliation.

Here, again, having a written policy for the handling of disruptive behavior which includes an avenue for assessing physician claims that they are engaging in "advocacy" is most useful.

SUGGESTED BYLAW PROVISIONS

The California Hospital Association and the California Medical Association each address standards of conduct in their model Medical Staff Bylaws. A side-by-side comparison is set forth below:

CHA **MODEL MEDICAL STAFF BYLAWS 2013**	**CMA** **MODEL MEDICAL STAFF BYLAWS 2013**
2.7 STANDARDS OF CONDUCT Members of the Medical Staff are expected to adhere to the Medical Staff Standards of conduct, including but not limited to the following: **2.7-1 General** **a.** It is the policy of the Medical Staff to require that its members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty and fair dealing with each other, and to promoting a caring environment for patients,	**2.7 MEMBERS' CONDUCT REQUIREMENTS** As a condition of membership and privileges, a medical staff member shall continuously meet the requirements for professional conduct established in these bylaws. Non-members with privileges will be held to the same conduct requirements as members. Except as provided in these bylaws, no other codes or policy restricting or defining conduct apply to the medical staff and its members. **2.7-1 Acceptable Conduct** Acceptable medical staff member conduct is not restricted by these bylaws and includes, but is not

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practitioners, employees and visitors. **b.** Rude, combative, obstreperous behavior, as well as willful refusal to communicate or comply with reasonable rules of the Medical Staff and the hospital may be found to be disruptive behavior. It is specifically recognized that patient care and hospital operations can be adversely affected whenever any of the foregoing occurs with respect to interactions at any level of the hospital, in that all personnel play an important part in the ultimate mission of delivering quality patient care. **c.** In assessing whether particular circumstances in fact are affecting quality patient care or hospital operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces—in addition to medical outcome—matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and their insurers (or third party payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services. **2.7-2 Conduct Guidelines** **a.** Upon receiving Medical Staff membership and/or privileges at the hospital, the member enters common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct. **b.** Members of the Medical Staff are expected to behave in a professional manner at all times and with all people—patients, professional peers, hospital staff, visitors, and others in and affiliated	limited to: (a). advocacy on medical matters; (b). making recommendations or criticism intended to improve care; (c). exercising rights granted under the medical staff bylaws, rules and regulations, and policies; (d). fulfilling duties of medical staff membership or leadership; (e). engaging in legitimate business activities that may or may not compete with the hospital. **2.7-2 Disruptive and Inappropriate Conduct** Disruptive and inappropriate medical staff member conduct affects or could affect the quality of patient care at the hospital and includes: (a). Harassment by a medical staff member against any individual involved with the hospital; (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation. (b). “Sexual harassment” defined as unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when

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with the hospital. **c.** Interactions with all persons shall be conducted with courtesy, respect, civility and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in and affiliated with the hospital. **d.** Complaints and disagreements shall be aired constructively, in a nondemeaning manner, and through official channels. **e.** Cooperation and adherence to the reasonable rules of the hospital and the Medical Staff is required. **f.** Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral. **2.7-3 Adoption of Rules** The Medical Executive Committee may promulgate rules further illustrating and implementing the purposes of this Section, including but not limited to, procedures for investigating and addressing incidents of perceived misconduct, and, where appropriate, progressive or other remedial measures. These measures may include [establishing a Professional Conduct Committee to oversee practitioner conduct issues,] alternative avenues for medical or administrative disciplinary action, which in turn may include but are not limited to conditional appointments and reappointments, requirements for behavioral contracts, mandatory counseling, practice restrictions, and/or suspension or revocation of Medical Staff membership and/or privileges.	(1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities. (c) Deliberate physical, visual or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the hospital; (e) Carrying a gun or other weapon in the hospital; (f) Refusal or failure to comply with these member conduct requirements. **2.7-3 Medical Staff Conduct Complaints** **2.7-3 Medical Staff Conduct Complaints** All complaints or reports will be discussed and decisions made in executive session. Complaints or reports of disruptive and inappropriate conduct by medical staff members are subject to review whether or not the witness or complainant requests or desires action to be taken. Complaints or reports must be in writing, and will be transmitted to the Department Chair and Chief of the Medical Staff, or to the medical staff officer designated by either the Chief of Staff or Medical Executive Committee. Complaints are shared with the subject member, who will be given the opportunity to respond in

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	writing. The Department Chair, in consultation with the Chief of Staff shall refer the matter immediately to the Medical Staff Aid Committee for evaluation, and monitoring and treatment if needed, if there is any indication that the member's health is implicated and the conduct at issue can be addressed by the Medical Staff Aid Committee without jeopardizing quality care or patient safety. The Department Chair, in consultation with the Chief of Staff shall determine if the complaint or report is obviously specious and warrants no further action. If the Department Chair, in consultation with the Chief of Staff determines no action is warranted, the decision is reported at the next Medical Executive Committee. This decision may be discussed and acted upon at the request of any Medical Executive Committee member with the support of the majority of the Medical Executive Committee members present at that meeting. Complaints not referred to the Medical Staff Aid Committee or nor dismissed by the Department Chair, in consultation with the Chief of Staff are referred to the appropriate department for peer review committee evaluation and investigation, if needed. The decision will be forwarded to the Medical Executive Committee. Any action taken shall be commensurate with the nature and severity of the conduct in question. If corrective action is decided by the Medical Executive Committee, the members will be afforded hearing rights per Article VIII. If the Medical Executive Committee decides no further action is necessary, the complaint will be closed and filed for up to two years and discarded thereafter. **2.7-4 Hospital Staff Conduct Complaints** Medical staff members' reports or complaints about the conduct of any hospital administrators, nurses or other employees, contractors, board members or

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	others affiliated with the hospital must be reduced to writing and submitted to the Chief of Staff or any medical staff officer. The Chief of Staff shall forward the complaint or report to the appropriate hospital authority for action. Reports and complaints regarding hospital staff conduct will be tracked through the medical staff office, which will report results of such results and complaints to the Medical Executive Committee. **2.7-5 Abuse of Process** Retaliation or attempted retaliation against complainants or those who are carrying out medical staff duties regarding conduct will be considered inappropriate and disruptive conduct, and could give rise to evaluation and corrective action pursuant to the medical staff bylaws.

THE JOINT COMMISSION'S SUGGESTIONS

The Joint Commission's Sentinel Alert offered a number of "suggested actions to address disruptive behavior. Each hospital and Medical Staff should consider the usefulness of the following:

- Educate all team members, both physicians and non-physician staff, on appropriate professional behavior as defined by the organization's Code of Conduct;
- Hold all team members accountable for modeling desirable behavior and enforce the Code of Conduct consistently and equitably among the staff;
- Develop and implement policies and procedures that address zero tolerance for intimidating and disruptive behaviors and non-retaliation clauses and policies to reduce the fear of intimidation;
- Develop an organizational process for addressing intimidating and disruptive behavior;

- Develop and implement a reporting system for detecting unprofessional behavior and possibly include an ombudsman service and patient advocates;

- Support surveillance with tiered non-confrontational interventional strategies starting with informal "cup of coffee" conversations and moving toward more detailed action plans;

- Document all attempts to address intimidating disruptive behavior.

THE ROLE OF THE WELL-BEING COMMITTEE

Experience also shows that certain individuals who exhibit disruptive and abusive behavior have underlining medical and psychological reasons that can be effectively addressed. The medical staff's process should provide for such a possibility.

A referral to a well-being committee for evaluation should be considered at the outset so that, in situations where it is possible, professional assistance, with requirements for modification of behavior, can be the first intervention used by the medical staff and disciplinary action can be employed only if it becomes necessary.

The availability of such a non-disciplinary and rehabilitative avenue may be the only chance to prevent the destruction of the physician's career. It is unquestionable that any restriction taken against the physician due to disruptive behavior is taken for "medical disciplinary cause or reason" and is reportable to the Medical Board of California (*Sahlolbei v. Providence Healthcare*, 112 Cal.App.4th 1137 (2003), and to the National Practitioner Data Bank (*Leal v. DHHS*, 623 Fed.Sup 1280 (11th Circuit 2010).

TC/SKD