

New Joint Commission Requirements Confirm Relationship Between Disruptive Behavior and Quality of Care

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Introduction

The Health Care Quality Improvement Act of 1986 (HCQIA),¹ provides immunity from liability to participants in the medical peer review process. Courts have applied HCQIA immunity to peer review actions taken against physicians who engaged in disruptive or unprofessional conduct that has been judicially acknowledged as having the potential to adversely affect patient care. Consistent with the wealth of case law acknowledging the connection between disruptive conduct and quality healthcare, Joint Commission accreditation standards now require hospitals and other healthcare facilities to adopt processes that address disruptive and intimidating behavior by staff.

Courts Applying HCQIA Immunity Recognize That Disruptive Behaviors Have the Potential to Affect Quality of Care

Under the HCQIA, hospitals, board members, hospital employees, peer review committees, individual members of the medical staff, and all others who give information in connection with peer review are immune from liability if their actions were taken in the reasonable belief that it was in furtherance of quality healthcare.²

Courts applying HCQIA immunity have held that peer review actions taken against physicians who engaged in disruptive or unprofessional conduct were based on the reasonable belief that the action was in furtherance of quality healthcare.³ At a minimum, quality healthcare requires physicians to possess at least a reasonable ability to work with others.⁴

The types of disruptive behaviors that the courts have recognized as having the potential to affect quality healthcare include but are not limited to outbursts, threats, and verbal abuse towards hospital staff; sexual harassment; inability to work cooperatively with others; and condescending treatment, harassment, and intimidation of patients.⁵

A hospital does not have to wait until a patient is injured to take corrective action against a disruptive physician.⁶ In *Meyers*, the court held that the hospital's concern—that the physician's behavior would continue until a patient was injured as a result of his actions—constituted a reasonable belief that the action was in furtherance of quality healthcare.⁷ The hospital did not have to



wait until a patient was injured or a nurse refused to work with the plaintiff to take corrective action.⁸

A significant number of federal and state courts have also expressly acknowledged that the disruptive conduct of a physician—in the sense of his or her inability to work in harmony with other healthcare personnel at the hospital—may have an adverse impact on overall patient care and is a ground for denying, suspending, restricting, refusing to renew, or revoking the staff appointment or clinical privileges of the offending physician.⁹

The Joint Commission Requirement That Hospitals Have Processes to Address Disruptive Behavior is Consistent With Judicial Recognition That Disruptive Behavior May Affect Quality Healthcare

The Joint Commission has now formally acknowledged that disruptive behavior may interfere with the provision of quality healthcare. The Joint Commission is a private organization authorized by the Centers for Medicare & Medicaid Services (CMS) to establish standards of care that hospitals must meet to remain accredited and eligible for participation in the Medicare and Medicaid programs. Effective January 1, 2009, The Joint Commission requires hospitals to address disruptive and intimidating behavior by staff—including physicians—to maintain their accreditation. The expectations and rationale for these new elements of performance under the Leadership Chapter (LD.03.01.01, EP## 4 and 5) were described as follows in a Joint Commission Sentinel Alert published in July 2008:

[i]ntimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. *To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.*¹⁰

The Joint Commission has defined intimidating and disruptive behaviors to include both “overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative behavior and attitudes during routine activities.” Such “overt and passive behaviors undermine team effectiveness and can compromise the safety of patients,” and “[a]ll intimidating and disruptive behaviors are unprofessional and should not be tolerated.”

In connection with its mandate that all hospitals and healthcare facilities adopt processes that address disruptive and intimidating behavior, The Joint Commission suggests a zero tolerance approach to behaviors that are egregiously intimidating and disruptive including but not limited to: (1) verbal outbursts and physical threats; (2) refusing to perform assigned tasks; (3) quietly exhibiting uncooperative attitudes during routine activities; (4) reluctance or refusal to answer questions, return phone calls, or pages; (5) condescending language or voice intonation; and (6) impatience with questions. The Joint Commission has specifically recommended implementing policies providing “zero tolerance for intimidating and/or disruptive behaviors,” as well as policies “reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior.”¹¹

The Joint Commission reiterates the importance of abating disruptive behaviors in a July 9, 2008, news release entitled “Joint Commission Alert: Stop Bad Behavior among Health Care Professionals.”¹² This release emphasizes that “rude language and hostile behavior among health care professionals goes beyond being unpleasant and poses a serious threat to patient safety and overall quality of care.” As noted by The Joint Commission President Mark R. Chassin, MD, “sometimes professionalism breaks down and caregivers engage in behaviors that threaten patient safety. It is important for organizations to take a stand by clearly identifying such behaviors and refusing to tolerate them.”

Conclusion

The Joint Commission requirements regarding disruptive behavior are consistent with judicial recognition that disruptive conduct may endanger patient care. Accordingly, peer review participants who seek HCQIA immunity for action taken against disruptive conduct can and should bring to the court’s attention the new Joint Commission requirements.

regularly viewed it as his obligation to criticize staff members at [the Hospital] for perceived incompetence or inefficiency”); *Gordon v. Lewistown Hosp.*, No. Civ.1:CV-99-1100, 2001 WL 34373013 (M.D. Pa. May 21, 2001), *aff’d*, 423 F.3d 184 (3d Cir. Pa. 2005) (immunity applied to expulsion based on physician’s outbursts at hospital staff, condescending treatment of his own patients and harassment and intimidation of other physician’s patients taken in furtherance of quality healthcare); *Meyers v. Logan Mem’l Hosp.*, 82 F. Supp. 2d 707, 714 (W.D. Ky. 2000) (immunity applied to denial of reappointment application based on physician’s temper, delinquent medical records, and inability to work cooperatively with others, which goes to quality of care); *Rooney v. Medical Ctr. Hosp.*, No. C2-91-1100, 1994 WL 854372 (S.D. Ohio Mar. 30, 1994) (immunity applied to suspension of physician whose abusive treatment of nurses and paramedic personnel had the potential of affecting the health and welfare of patients); *Manasra v. St. Francis Med. Ctr., Inc.*, 764 So.2d 295 (La. Ct. App. 2000) (pattern of disruptive behavior exhibited by physician, including profanity, threats, and daily outbursts, along with the evidence of deterioration in patient care, provided sufficient basis for the peer review committee to form a reasonable belief that termination of physician’s medical staff privileges was necessary to further quality healthcare and HCQIA immunity, therefore, applied); *Catipay v. Humility of Mary Health Partners*, No. 2005-T-0030, 2006 WL 847235 (Ohio Ct. App. Mar. 31, 2006) (HCQIA applied to suspension of physician’s privileges taken with reasonable belief that the action was in furtherance of quality healthcare where physician engaged in inappropriate and disruptive behavior toward hospital staff, including making what were perceived as threats, and verbally abused other physicians); *Morgan v. PeaceHealth, Inc.*, 14 P.3d 773 (Wash. Ct. App. 2000) (upholding immunity when physician’s privileges suspended for sexual harassment and inappropriate behavior with patients).

6 *Meyers*, 82 F. Supp. 2d at 714; *Rooney*, 1994 WL 854372, at *3.

7 *Myers*, 82 F. Supp. 2d at 714..

8 *Id.*; see also *Bryan*, 33 F.3d at 1324 (hospital was justified in terminating physician who “was disruptive and interfered with the important work of other employees,” even though he was acknowledged to be an excellent surgeon).

9 See, e.g., *Mahmoodian v. United Hosp. Ctr., Inc.*, 185 W.Va. 59, 69 (1991) (defining a disruptive practitioner as someone who is, among other things, contentious, threatening, unreachable, insulting, and frequently litigious). See also *Leach v. Jefferson Parish Hosp.*, 870 F.2d 300, 303 (5th Cir. 1989) (hospital, which clearly has an interest in providing quality medical care to its patients, has a duty to intervene if a physician is disruptive or has personal problems); *Gekas v. Seton Corp.*, No. M2006-00454-COA-R3-CV, 2008 WL 836399 (Tenn. Ct. App. Mar. 28, 2008) (granting summary judgment to hospital that denied reappointment to physician who engaged in disruptive conduct for several years, including pattern of rudeness and insults directed against nurses and altercations with other physicians); *Siegel v. St. Vincent Charity Hosp. & Health Ctr.*, 520 N.E.2d 249 (Ohio Ct. App. 1987) (hospital could reject physician’s application for reappointment to medical staff based on physician’s non-cooperative and disruptive behavior and public disparagement of hospital, although physician was professionally competent); *Gaenslen v. Board of Directors of St. Mary’s Hosp. and Med. Ctr.*, 185 Cal. App.3d 563 (1985) (hospital was justified in terminating physician’s medical staff appointment and clinical privileges due to ten years of disruptive conduct, including treating hospital personnel with disdain and contempt); *Even v. Longmont United Hosp. Ass’n*, 629 P.2d 1100, 1103 (Col. Ct. App. 1981) (hospital justified in terminating physician for unprofessional conduct including disruptive personal and professional relationships with other operating room personnel); *Pick v. Santa Ana-Tustin Community Hosp.*, 130 Cal. App.3d 970 (1982) (physician’s lack of ability to work with others in hospital setting presented real and substantial danger that patients treated by him at hospital might receive other than a high quality of medical care sufficient to support denial of application for admission to medical staff); *Silver v. Queen’s Hosp.*, 629 P.2d 1116 (Haw. 1981) (physician’s abrasive and disruptive conduct and his questionable professional ethics and character were sufficient to support denial of staff privileges); *Ladenheim v. Union County Hosp. Dist.*, 394 N.E.2d 770 (Ill. Ct. App. 1979) (physician’s inability to work with other members of hospital staff was in itself sufficient grounds to deny him staff privileges); *Bricker v. Sceva Speare Mem’l Hosp.*, 281 A.2d 589 (N.H. 1971) (hospital was justified in refusing to reappoint physician, who was an active disruptive force on operation of hospital and whose actions had “adverse effect upon the smooth-working relationships so necessary for adequate and essential health care”).

10 See Joint Commission Sentinel Alert, July 2008 (emphasis supplied).

11 *Id.*

12 Available at www.jointcommission.org/NewsRoom/NewsReleases/nr_07_09_08.htm.

1 42 U.S.C. §§ 11101-11152.

2 See *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 632-33 (3d Cir. 1996).

3 See, e.g., *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461 (6th Cir. 2003) (upholding immunity when physician’s reappointment was denied because of failure to timely disclose disciplinary actions in another state, personality problems, and various incidents of disruptive behavior); *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 835 (3d Cir. 1999) (affirming summary judgment in favor of hospital based on HCQIA immunity for peer review decisions involving surgeon characterized as “a disruptive force in the hospital”).

4 *Rooney v. Medical Ctr. Hosp.*, No. C2-91-1100, 1994 WL 854372, at *3 (S.D. Ohio Mar. 30, 1994).

5 See, e.g., *Bryan v. James E. Holmes Reg’l Med. Ctr.*, 33 F.3d 1318, 1335 (11th Cir. 1994) (granting immunity when physician’s privileges were revoked for inappropriate and unprofessional behavior stemming from his “being a volcanic-tempered perfectionist, a difficult man with whom to work, and a person who