



New Systemic Approaches to Disruptive Behavior

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Disruptive behavior in health care organizations has long been recognized as a threat to patient safety.¹ Physicians who exhibit disruptive behavior frequently claim to be motivated by unaddressed patient safety and quality concerns.² Hospitals can miss opportunities to improve care systems and mitigate risks by failing to address the quality issues raised by physicians whose disruptive behavior undermines the legitimacy of their concerns. Attorneys have a critical role to play in helping health care organizations recognize and address the multiple risks presented by disruptive physician behavior.

As this article discusses, systemic approaches may prove more effective than individually focused interventions in addressing interdependent quality and behavioral issues, thereby mitigating a variety of potential risks.

Underlying Reasons for Disruptive Behavior and Effects on Patient Care

Physicians have become increasingly vocal about the multiplicity of factors causing them dissatisfaction, stress, and burnout. In addition to multiple, uncoordinated mandates from federal and state authorities, regulatory bodies, insurance providers, and certifying organizations, physicians face persistent concerns about malpractice risk; the burden of

documentation in electronic medical records; the rise of health care consumerism; increased outcomes transparency; the effects of payer-tiering on established clinical relationships; the rise of productivity-based reimbursement; direct competition through new retail forms of practice; and the perceived loss of autonomy through adherence to checklists and clinical protocols.³ While some mandates, such as meaningful use, are being revised, new merit-based incentive programs to measure physician effectiveness and quality are emerging.⁴ Moreover, as health care systems consolidate, constraints on physician autonomy contributing to uncertainty and stress may include new clinical leadership, disrupted affiliations, and the imposition of religious directives.

These multiple stressors contribute to physicians' perceptions that they are unable to positively impact the clinical environment. For all of these reasons, physicians are reporting increased frequency and severity of burnout across all specialties.⁵ Stress and burnout can lower morale, lead to chronic disruptive behavior, and jeopardize patient safety through impaired decision making, difficulty in communicating effectively, irritability, and conflict.⁶

The link between disruptive behavior and threats to patient safety led the Joint Commission in 2008 to issue its Sentinel Event Alert on *Behaviors That Undermine a Culture of Safety*, noting that such behaviors lead to medical errors and preventable adverse outcomes. Since clinicians work in teams, these behaviors can result in reduced communication, collaboration, and information exchange.⁷ Disruptive behavior's impact on teamwork and adverse outcomes has been linked in a variety of settings.⁸ Poor communication among members of the health care team is costly in terms of medical liability. A recent CRICO study demonstrated that communication failures accounted for 1,744 deaths and \$1.7 billion in malpractice costs, and were a factor in 30% of cases examined between 2009 and 2013.⁹ Disruptive behavior

presents additional clinical risks: it inhibits compliance with and implementation of new practices;¹⁰ and, when witnessed by patients, undermines their confidence in the physician and the institution.¹¹

Methods of Identifying and Addressing Disruptive Behavior

Many health care organizations have adopted an Enterprise Risk Management (ERM) approach to ensure that organizational risks are identified, prioritized, mitigated, and prevented. An ERM plan typically classifies risks by domain and considers their frequency and severity in determining priorities for strategic response.¹² When disruptive physician behavior is considered through an ERM framework, it may be seen to transverse the risk domains of Finance; Human Capital; Strategy; Legal and Regulatory; Reputation; and Operational/Clinical, with the potential to create significant negative synergistic effects.

For example, disruptive physician behavior clearly lies within the risk domain of Human Capital, since it directly undermines morale and contributes to staff burnout. Team members who feel disrespected or intimidated frequently choose to leave the organization rather than endure a hostile environment.¹³ Workarounds commonly are employed to relieve staff of interaction with physicians known to exhibit disruptive behavior. Ultimately, health care organizations may seek to terminate their relationship with productive and talented clinicians when they are unable to rein in their disruptive behavior. Staff turnover, which involves hiring, training, and loss of productivity, is extraordinarily costly to health care organizations.¹⁴

The eight-year-long saga of *Fahlen v. Sutter Health*, litigated in California state courts, illustrates the risks presented when a hospital fails to address multiple complaints of disruptive physician behavior, reportedly motivated by quality concerns, in a timely and effective manner. From 2004–2008, Memorial Medical Center (Memorial), part of 24-hospital Sutter Health, received 17 complaints that Dr. Fahlen, a nephrologist, was abusive to nurses. However, Dr. Fahlen also reported to hospital authorities that certain nurses failed to follow his instructions, in some cases endangering patients' lives. Due to his history of abusive behavior, Dr. Fahlen was terminated from his medical group in 2008, and the hospital Medical Executive Committee (MEC) subsequently declined to renew his staff privileges.

A judicial review committee of six physicians later found no professional incompetence and reversed the MEC decision. The hospital board subsequently reversed the review committee, finding that Dr. Fahlen's conduct was not acceptable and was directly related to the quality of medical care at the hospital. Rather than filing a mandamus action to set aside the peer review decision, Dr. Fahlen sued under California's whistleblower law, alleging retaliation for his complaints regarding patient safety.

In February 2014, the California Supreme Court ruled that Dr. Fahlen was not required to exhaust administrative remedies in the hospital peer review process before proceeding with his civil complaint for retaliation under California's whistleblower statute.¹⁵ A superior court judge in June 2015 overturned the hospital's denial of privileges, holding the hospital should have followed the judicial review panel's decision. Rather than appeal this ruling, the hospital agreed to settle the matter and to reinstate Dr. Fahlen's privileges.

Fahlen v. Sutter demonstrates the lengthy, expensive, and contentious consequences of a hospital's failure to effectively manage disruptive physician behavior and related quality issues. Attorneys have a critical role to play in ensuring that the health care organizations they counsel are aware of the multiple risks of disruptive physician behavior, particularly when such behavior purportedly is motivated by quality concerns, and are managing them as part of an overall ERM plan.

Best Practices for Health Care Attorneys

Since the 2008 Joint Commission Sentinel Event Alert and promulgation of leadership standards addressing behavior that undermines a culture of safety, health care organizations have developed codes of conduct and processes for identifying and managing disruptive behavior. Online event-reporting systems; compliance hotlines; patient complaint systems; ongoing professional practice review; and complaints to human resources departments, division chiefs, chairs, and chief medical officers all are ways that organizations may learn about disruptive physician behavior.

In academic medical centers, complaints also may be made through deans' offices and professionalism committees. In multi-specialty groups and practice plans, complaints may go directly to clinical leaders. While multiple venues for receiving complaints of disruptive behavior are desirable, variability in organizational processes for investigating and remediating them creates legal and accreditation risks.

Attorneys advising health care organizations should ensure that applicable policy and procedures direct all complaints of disruptive physician behavior, regardless of how received, to an appropriately designated and trained individual or committee for investigation under established protocols. Protocols should include the referral of any patient-safety and quality issues raised by the physician to designated departments for event analysis and the implementation of process improvement efforts, when appropriate. Engaging the complaining physician in quality-improvement efforts can have beneficial effects: the organization may be able to improve quality, enhance teamwork, and avoid the costly consequences of adversarial actions.

By way of example, the *Fahlen* case discussed above is illustrative. By failing to investigate patient-safety issues linked with the disruptive behavior, or to engage Dr. Fahlen and his care

teams in constructive resolution of the patient safety concerns he raised, the hospital ultimately undermined its own peer review process. Hospitals that forego such opportunities to address quality issues and improve care processes may inadvertently give credence to later whistleblower claims.

The health care organization's response to persistent disruptive behavior generally becomes the responsibility of the department chair, medical staff president, or chief medical officer.¹⁶ Health care organizations should take care to guard against inconsistent responses by different departments whose efforts are not well coordinated. Documentation of the investigation and resolution of disruptive behavior should be handled in a manner that allows for consistency, confidentiality, and appropriate data collection, so that patterns of behavior can be detected and managed. Enlisting the hospital's performance improvement department in documenting disruptive behavior is a way to ensure that it becomes part of the Ongoing Professional Practice Evaluation for credentialing consideration, and that any quality issues raised by physicians are referred for appropriate investigation and follow-up. The integration of information concerning disruptive behavior into the credentialing process also serves to protect its confidentiality.

Many hospitals have adopted policies that provide for investigation and remediation under a graduated system of interventions, culminating—in the most egregious or repetitive cases—in referral to a medical staff committee for possible corrective action. Attorneys supporting an ERM approach should ensure that a code of conduct is incorporated in the medical staff bylaws, and that the organizational process to respond to complaints of disruptive behavior is set forth in writing, widely promulgated, consistently applied, appropriately documented, and accountable through organizational oversight.

In addition, the individuals responsible for investigating and remediating disruptive behavior must be appropriately resourced, trained, and overseen by the organization in the implementation of graduated interventions. If professional coaching or counseling is determined to be an appropriate intervention, consideration should be given to arranging for such services through a health care attorney to protect the information and its subsequent use in the organization's decision making. When disruptive behavior results in a referral for possible corrective action, the hospital attorney should ensure that all requirements set forth in the bylaws are followed, and that any quality issues emerging during the process are appropriately referred for institutional follow-up. Complaints of disruptive behavior and their resolution should be reported to the appropriate hospital quality committee, to ensure institutional oversight and ongoing risk mitigation.

Various system-level solutions to the problem of physician disruptive behavior have been proposed. Noting the failure of health care to adequately assess physician performance deficiencies that threaten patient safety, analysts Leape and Fromson advocated, in 2006, for a routine, formal, proac-

tive system of monitoring at the hospital level, supported by a national effort to develop better measures for assessing physician performance; expansion of the number of assessment programs for physicians with competence or behavioral problems; and development of and supervision of remediation programs.¹⁷

Specifically, they called for the Federation of State Medical Boards, the American Board of Medical Specialties, and The Joint Commission to develop and require, for all physicians, standards and measures for annual data-based assessment of physician performance, as well as more state and regional centers for assessment and remediation of physicians with performance deficiencies. Ten years later, metrics for physician performance assessment have not been standardized, and there is considerable variability in the resources offered through state medical boards for assessment and remediation.

Conclusions and Takeaways for Attorneys

Interventions employed by health care organizations to address disruptive physician behavior, even when utilizing 360° or group-feedback programs to gather information, tend to focus on the behavior of individual physicians, without assessing the overall functioning of the clinical teams affected or related quality issues that may be motivating the behavior. This may explain why disruptive behavior typically recurs, even following remediation efforts.¹⁸ When underlying quality concerns and team dynamics are not addressed, a physician who has participated in remediation efforts may continue to be triggered by the clinical environment that they believe is impeding good patient care.

On the other hand, a systemic interventional approach to disruptive behavior aims to ameliorate the behavior while simultaneously identifying and addressing the quality issues raised, and creating conditions to prevent the behavior's recurrence. Coaches trained in a systems-centered approach will gather data on team interactions and related quality issues in an effort to understand what motivates the disruptive behavior, how it affects the team, and whether the physician can be engaged in implementing solutions so as to prevent its recurrence. The participation of clinical leadership is essential to this approach.

A comprehensive approach combining interdependent behavioral and clinical interventions was found to result in improvements to a clinical system (surgical scheduling) and to effectively prevent recurrence of a surgeon's disruptive behavior by engaging him directly in oversight of the redesigned process.¹⁹ Similarly, in a case involving disruptive behavior and poor morale at a day-surgery center, ascribed to a lack of clarity about roles and responsibilities, a systemic approach that engaged the entire clinical team in clarifying structures and processes was successful in eliminating the disruptive behavior and improving morale.²⁰

Evidence for the efficacy and sustainability of systemic interventional approaches is sparse, but compelling. Given the

typical recurrence of disruptive behaviors following individual physician interventions, systemic approaches should be considered as part of the overall risk-mitigation strategy for disruptive behavior. Successful systemic interventions have the potential to introduce system innovation, improve quality, and substantially mitigate the downside risks of disruption.

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