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What Can Be Done About A Disruptive Physician? A Legal Analysis

Samuel D. Hodge, Jr.*

House, a medical drama about an infectious disease specialist, entertained television audiences for years as the irascible and pill-popping physician solved medical mysteries with the zeal of a modern-day Sherlock Holmes while playing mind games with his coworkers. Uncanny intuition and eccentric thinking earned the physician great respect but his bullish behavior and antisocial tendencies were a distraction at the hospital.¹ Not only did Dr. House clash with his fellow physicians but he also insulted patients, flouted hospital rules and caused great conflict with the hospital administrators.² In fact, his actions often crossed the line into obnoxiousness and rage causing the hospital staff to tiptoe around his dysfunctional behavior.³

In the real world, Dr. House would be labeled a “disruptive physician” and would be subjected to disciplinary action including the loss of his hospital privileges. This article will explore the problems caused by being labeled a disruptive physician in a legal context with a focus on the peer review process and the relevant court cases.

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1. *House (TV Series)*, WIKIPEDIA, [https://en.wikipedia.org/wiki/House_\(TV_series\)](https://en.wikipedia.org/wiki/House_(TV_series)), (last visited Sept. 14, 2019).

2. *Id.*

3. Bob Wachter, *Gregory House, MD, RIP*, HOSPITAL LEADER BLOG (May 21, 2012), <https://thehospitalleader.org/gregory-house-md-rip/>.

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I. Introduction

The practice of medicine is filled with stress from being involved in life and death decisions, to declining revenues while practicing in a heavily regulated environment.⁴ These facts have triggered the quick response by some physicians to use regulatory schemes to advance their own personal agendas and to protect personal interests.⁵ Unfortunately, these rules and regulations, which are not well understood by most medical professionals, have caused a great deal of animosity and frustration, leading some doctors to become “disruptive physicians.”⁶

The troublesome physician causes untold medical, legal, and psychological problems in the workforce,⁷ and most health care managers are ill prepared to deal with these doctors.⁸ For

4. Michael J. Grogan & Paul Knechtges, *The Disruptive Physician: A Legal Perspective*, 20 *ACAD. RADIOLOGY* 9, 1069–73 (2013).

5. Zachary L. Erwin, *Analyzing the Disruptive Physician: How State and Federal Courts Should Handle Whistleblower Cases Brought by Disruptive Physicians*, 44 *DUQ. L. REV.* 275, 275 (2006).

6. *Id.* at 276.

7. *Id.*

8. Eugene Fibuch & Jennifer J. Robertson, *Bringing Value: Dealing Fairly With Disruptive Physicians*, *AM. ASS’N PHYSICIAN LEADERSHIP* (Mar. 8, 2019), <https://www.physicianleaders.org/news/bringing-value-dealing-fairly->

example, disruptive physicians can lead to a hostile work environment, cause morale problems, increased litigation, compromised patient care, communication issues, and obstruction in the regular running of the organization.⁹ As noted by Alexander Vaccaro M.D., the President of the Rothman Institute, “There is no place in medicine for disruptive physicians and every study that has examined the issue has concluded that a disruptive doctor increases the chance of an adverse event. In fact, these physicians have a higher complication rate and receive negative feedback in patient satisfaction surveys.”¹⁰ Addressing this conduct head-on is critical, but recognizing the proper course of remedial action can be a daunting task.¹¹

II. What is a Disruptive Physician?

No single definition exists to describe a disruptive physician but a number of organizations and court decisions have addressed the issue. Some medical professionals claim that they have an “instinctive understanding” of what represents disruptive behavior and do not need guidance.¹² On the other hand, the Court in *Gordon v. Lewistown* defines a disruptive physician as one who is unruly, “contentious, threatening, unreachable, insulting and frequently litigious. He will not, or cannot, play by the rules, nor is he able to relate to or work well with others.”¹³ It is important to note, however, that a sole occurrence of troublesome behavior is inadequate to be labeled a disruptive physician and anticipating complete harmony in the workplace is unrealistic. The tag should also not be used to

disruptive-physicians.

9. Erwin, *supra* note 5, at 275–76.

10. Alexander Vaccaro, M.D., Ph.D, MBA, is an orthopedic surgeon and the President of Rothman Institute, one of the largest orthopedic practices in the country. He is also the Richard H. Rothman Professor and Chair in the Department of Orthopaedic Surgery, and a Professor of Neurosurgery at Thomas Jefferson University in Philadelphia, Pennsylvania. His comments were obtained in a telephone interview conducted by the author on September 20, 2019.

11. Alicia Gallegos, *Disruptive Physicians: Is This an HR or MEC Issue?*, MDEdge (Sept. 16, 2018), <https://www.mdedge.com/internalmedicine/article/174921/businessmedicine/disruptive-physicians-hr-or-mec-issue>.

12. Grogan & Knechtges, *supra* note 4, at 2.

13. *Gordon v. Lewistown Hosp.*, 714 A.2d 539, 544 (Pa. Commw. Ct. 1998).

describe a doctor who has had a bad day or demonstrates an occasional outburst that is out of character. Nor should the label apply to a physician who has quirks, tends to be disagreeable, or annoys others on the medical staff.¹⁴ Rather, the characterization should be reserved for those who show a pattern of seriously inappropriate conduct that is “deep-seated and habitual.”¹⁵ A single incident that is improper must still be addressed but the label “disruptive physician” is reserved for more sustained and inappropriate behaviors over a period of time.¹⁶

III. The Problem

As the sophistication and intricacies of medicine and managed health care increase, the need to work in a conducive atmosphere of cooperation intensifies. Contemporaneously, the pressures, burdens, and distractions involving physicians correspondingly escalate. Because doctors occupy an esteemed position in society, inappropriate actions by these individuals become magnified and have a greater probability for disruption.¹⁷

Acknowledged in the medical literature for more than a century,¹⁸ there is little evidence to demonstrate that the number of episodes of disruptive physicians has increased in recent years, but the problem has moved to the forefront of healthcare management. Likewise, doctors who demonstrate inappropriate behavior are being sanctioned with greater frequency.¹⁹

A. Statistics

14. Grogan & Knechtges, *supra* note 4, at 3; *See also* Mahmoodian v. United Hosp. Ctr., 404 S.E.2d 750 (W. Va. 1991).

15. Norman T. Reynolds, *Disruptive Physician Behavior: Use and Misuse of the Label*, 98 J. MED. REG. 1, 10 (2012).

16. *Id.* at 9–10.

17. Brian J. Santin & Krista L. Kaups, *The Disruptive Physician: Addressing the Issues*, BULL. AM. COLL. SURGEONS (Feb. 1, 2015), <http://bulletin.facs.org/2015/02/the-disruptive-physician-addressing-the-issues/>.

18. Llewellyn E. Piper, *Addressing the Phenomenon of Disruptive Physician Behavior*, 22 HEALTH CARE MANAGER 335, 335–39 (2003).

19. Santin & Kaups, *supra* note 17.

Most physicians and other health care workers have seen their contemporaries engage in disruptive conduct with co-employees, patients, and other individuals.²⁰ In fact, more than seventy percent of doctors surveyed indicate that disruptive conduct happens at least once a month at their workplace, and more than ten percent admit that such episodes occur on a daily basis.²¹ This disruptive behavior runs the gamut from cursing to the refusal to follow established procedures.²² Most responders expressed concern about the consequences of this inappropriate conduct on their practices, and nearly all are of the opinion that the disruptive physician affects patient care. Surprisingly, twenty-six percent of doctors acknowledged that they have engaged in disruptive conduct at some point during their careers and the most proffered reasons for these inappropriate actions are “workload and learned behaviors.”²³

Demographically, nurses are the main victims of this unseemly conduct,²⁴ and a number have left their jobs as a result.²⁵ The greatest offenders are those with the highest stress level jobs, with surgeons being labeled the greatest culprits, followed by obstetricians/gynecologists, orthopedic doctors, and primary care physicians.²⁶ Other specialists with less frequent episodes include cardiologists, anesthesiologists, ophthalmologists, cardiac/vascular surgeons, kidney specialists, radiologists, oncologists, and psychiatrists.²⁷

B. Conduct That Is Disruptive

20. *Id.*

21. Owen MacDonald, *Disruptive Physician Behavior*, QUANTIAMD 1, 2 (May 15, 2011), http://www.quantiamd.com/q-qcp/Disruptive_Physician_Behavior.pdf.

22. *Id.* at 2.

23. *Id.*

24. Stephen Lazoritz, *Don't Tolerate Disruptive Physician Behavior*, AM. NURSE TODAY (Apr. 11, 2011), <https://www.americannursetoday.com/dont-tolerate-disruptive-physician-behavior-2/>.

25. Charles P. Samenow et. al., *ACME Course Aimed at Addressing Disruptive Physician Behavior*, PHYSICIAN EXEC. 32 (Jan.–Feb. 2008), <https://www.mc.vanderbilt.edu/root/pdfs/cph/Samenow.pdf>.

26. Alan H. Rosenstein et. al., *Legal Entanglements in Dealing with Disruptive Behavior*, PHYSICIAN LEADERSHIP J., May–June 2016, at 46, 48 fig. 2.

27. *Id.*

Inappropriate conduct takes many forms, with the highest level of encounters being degrading comments, insults, and yelling. Other types of disruptive behavior are less obvious but no less concerning. These include a physician's refusal to cooperate with others and the inability to adhere to established protocols. Conduct which occurs less frequently includes physician assaults, discriminatory behavior, incompetence, retaliation, spreading malicious rumors, throwing objects, and substance abuse.²⁸ Female physicians are slightly less likely to engage in disruptive conduct as compared to their male counterparts.²⁹

It is believed that disruptive physicians direct their actions against those who are perceived as having a status below the doctor. It is theorized that the hierarchical character of the medical profession has produced alphas who feel compelled to flaunt their status. Therefore, it should come as no surprise that one study ascertained that fifty percent of the conflicts dealing with disruptive doctors involve coworkers with less professional clout.³⁰

Critics of this label maintain that being designated a disruptive physician has been applied improperly by hospital management to jettison unwanted competition and anti-administration practices. It is also asserted that the phrase "disruptive physician" is buried in the bylaws and left intentionally broad, subjective, and undefined so that health care executives can construe it anyway they wish.³¹ Therefore, it is critical that hospitals implement rules and regulations that will assist them in the handling of disruptive doctors while shielding physicians from bogus claims of disruptive conduct.³²

IV. Remedial Measures

28. MacDonald, *supra* note 21, at 4–5.

29. *Id.* at 5.

30. Brian M. Peters, *Disruptive or Targeted Physician?: Compliance Strategies*, HOSP. & HEALTH SYS. INST., February 9, 2006, Am. Health Law. Ass'n, AHLA-Papers P0209-608 (citing David O. Weber, *Poll Results: Doctors' Disruptive Behavior Disturbs Physician Leaders*, PHYSICIAN EXEC., Sept.–Oct. 2004, at 6).

31. Lawrence R. Huntoon, *Abuse of the "Disruptive Physician" Clause*, 9 J. AM. PHYSICIANS AND SURGEONS 68, 68 (2004).

32. Peters, *supra* note 30, at 4.

A. The American Medical Association

The first remedial attempt by the medical profession occurred at the 1999 Annual Meeting of the AMA House of Delegates who adopted Resolution 9 (A-99) dealing with the disruptive physician. The pronouncement requested the AMA to “identify and study behavior by physicians that is disruptive to high quality patient care.”³³ The end result was the enactment of AMA Policy E-9.045 titled *Physicians with Disruptive Behavior*. This rule of ethics labels disruptive behavior as personal conduct, whether verbal or physical, that negatively affects or that potentially may adversely impact patient care. This inappropriate conduct is not limited to those actions that interfere with one’s ability to work with others on the health care team. Physician criticism, however, that is provided in good faith with the intent of improving patient care should not be classified as disruptive behavior.³⁴

The AMA also published a Model Medical Code of Conduct that can be used by health care facilities in drafting their bylaws.³⁵ This Code defines disruptive behavior as “any abusive conduct including sexual or other forms of harassment, or other forms of verbal or nonverbal conduct that harms or intimidates others to the extent that the quality of care or patient safety likely would be compromised.”³⁶ Inappropriate behavior is discouraged, but if such conduct persists, it will be transformed into disruptive behavior. Examples include:

belittling or berating patients or members of their
care team, use of profanity or disrespectful

33. Dudley M. Stewart, Jr., *Physicians with Disruptive Behavior, Report of the Council on Ethical and Judicial Affairs, CEJA Report 3-1-09*, AMERICAN MEDICAL ASS’N 1, 1 (2009), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/i09-ceja-physicians-disruptive-behavior.pdf>.

34. *Id.* at 2 (citing AMA Opinion 9.045 – Physicians with Disruptive Behavior).

35. AMERICAN MEDICAL ASS’N, Model Medical Staff Code of Conduct (2012), <https://www.slideshare.net/BarneyCohen/amamedicalstaffcodeofconduct> (last visited Oct. 4, 2019).

36. *Id.* at 1.

language, inappropriate comments written in a patient's chart, blatant failure to respond to a patient's needs, deliberate lack of cooperation with members of the medical staff, the deliberate refusal to return calls, and use of intentionally demeaning language that negatively impacts patient care.³⁷

The Code goes on to note that complaints about a physician should be in writing and directed to the president of the medical staff. A copy of the complaint, Code of Conduct, and bylaws should be given to the accused within thirty days. In turn, the offending member shall have the opportunity to respond in writing.³⁸

B. The Joint Commission

The Joint Commission, which is the accrediting agency for more than 22,000 health care organizations in the United States,³⁹ published Standard LD.03.01.01. This provision acknowledges that a disruptive physician engages in "behavior that intimidates others and affects morale or staff turnover[,] undermines a culture of safety and can be harmful to patient care."⁴⁰ As a result, the Joint Commission requires health care organizations to establish a code of conduct that defines behaviors that are "acceptable," "disruptive," and "inappropriate."⁴¹

This problem is so significant that the Joint Commission subsequently issued a Sentinel Event Alert which notes that intimidating and disruptive behaviors can lead to medical errors, poor patient satisfaction, increased cost of care, and

37. *Id.* at 2–3.

38. *Id.* at 5.

39. *About the Joint Commission*, JOINT COMMISSION, https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx (last visited Oct. 4, 2019).

40. *LD.03.01.01: Leaders Create and Maintain a Culture of Safety and Quality Throughout the Hospital*, JOINT COMMISSION 1, 1 <https://medschool.ucla.edu/workfiles/Site-AcademicAffairs/Events/17.Joint-Commission.pdf> (last visited Oct. 4, 2019).

41. Stewart, Jr., *supra* note 33, at 1–2.

avoidable adverse outcomes.⁴² In response to criticism that the term “disruptive behavior” is both ambiguous and inaccurate, the definition was changed to “behavior or behaviors that undermine a culture of safety.”⁴³

C. Federation of State Medical Boards

The Federation of State Medical Boards recognized the need to issue guidance on the disruptive physician when it issued the 2000 Report of the Special Committee on Professional Conduct and Ethics, as well as in the 2011 Policy on Physician Impairment.⁴⁴ The Special Committee’s Report defines disruptive behavior as “personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care.”⁴⁵ Furthermore, disruptive behavior is not a diagnosis but a descriptive label that impairs the ability of the healthcare team to operate effectively, thereby placing patients at risk. More specifically, it identified several ways in which disruptive conduct interferes with the doctor/patient relationship:

1. The physician’s inappropriate behaviors or emotional outbursts shift the physician’s focus from the patient, which can result in errors in clinical judgment and performance.
2. Physician’s emotional outbursts or other inappropriate behavior can increase apprehension and anxiety of the physician’s patients as well as other patients who may witness such outbursts and inappropriate behavior.

42. JOINT COMMISSION, *Behaviors that Undermine a Culture of Safety* (July 9, 2008), https://www.jointcommission.org/assets/1/18/SEA_40.pdf.

43. *Joint Commission Changes Term “Disruptive Behavior” in the Standards*, HCPRO (Nov. 10, 2011), <https://www.hcpro.com/ACC-273165-851/Joint-Commission-changes-term-disruptive-behavior-in-the-standards.html>.

44. Reynolds, *supra* note 15, at 8.

45. Federation of State Medical Boards, *Report of the Special Committee on Professional Conduct and Ethics* 1, 5, (Apr. 2000), <http://www.fsmb.org/siteassets/advocacy/policies/report-of-the-special-committee-on-professional-conduct-and-ethics.pdf>.

3. Decreased effectiveness of the entire health team. Peers, nurses, allied health professionals, and other members of the health care team may be intimidated and anxious, causing a loss of their clinical focus and productivity and thereby increasing the propensity for medical errors.

4. Decrease in effective communications among the health care team.⁴⁶

The Report went on to note that disruptive behavior in doctors is frequently the result of underlying pathology such as: “(1) addiction (2) stress (3) psychiatric disorders (e.g., bipolar disorder) or (4) personality disorders (e.g., narcissism).”⁴⁷ Personality disorders seem to be the cause of most referrals for disruptive behavior which may be treated, without or concurrent with punitive action.⁴⁸

D. Response by the States

States have also taken steps to curb unprofessional medical conduct. For instance, New York lists a number of ways that individuals can engage in professional misconduct under its public health law including “willfully harassing, abusing, or intimidating a patient either physically or verbally.”⁴⁹ The Texas Medical Association deems a health care professional who engages in conduct that leads to a breakdown in safety measures or acts in an intimidating manner towards a member of the medical staff to be engaged in disruptive behavior.⁵⁰ Pennsylvania enacted the Peer Review Protection Act which provides that one offering information to any review organization shall be granted immunity unless the information is not related to the functions of the review entity or if the

46. *Id.* at 5–6.

47. *Id.* at 6.

48. *Id.*

49. N.Y. Educ. § 6530(31) (McKinney 2008).

50. Crystal Conde, *Joint Commission Tries to Regulate Physicians' Behavior*, TEX. MED. (Dec. 2009), <https://www.texmed.org/Template.aspx?id=8189>.

materials provided are false and the individual knew or had reason to think the material was false.⁵¹

Failure of the facility to implement remedial measure to deal with disruptive physicians can result in expensive litigation. This is evidenced by a number of costly discrimination/harassment lawsuits against health care facilities as the result of the disruptive physician.⁵² For instance, *Chopourian v. Mercy General Hospital* involved a federal matter in which the jury awarded \$168 million to a forty-five-year-old physician's assistant who claimed that she was tormented and harassed by the surgeons and medical staff.⁵³ The plaintiff testified that one harasser informed her, "you'll give in to me" and a surgeon told her that "I'm horny" and slapped her buttocks.⁵⁴ A "bullying surgeon" stuck her with a needle and another called her a "stupid chick" in the operating room.⁵⁵

V. Peer Review Immunity

Interacting with disruptive physicians can be a time-consuming and emotionally exhausting endeavor for both management and the organization. Nevertheless, health care leaders have a duty to investigate and stop unprofessional conduct in the workplace.⁵⁶ This requires the implementation of an organized approach such as educating the staff as to what constitutes improper behavior and to clearly identify the penalties for engaging in such conduct.⁵⁷ For example, a code of conduct or bylaws should be created which applies to all members of the health care team. These directives should define what constitutes appropriate and inappropriate behavior in

51. 63 PA. STAT. and CONS. STAT. ANN. § 425.3(a) (West 2019).

52. Alice Gosfield, *2013 Health Law Handbook*, Section 11:2. Scope of the Problem, at *4.

53. Eugene Lee, *Largest Sexual Harassment Verdict in History - \$168 Million*, CAL. LAB. & EMP. L., <https://calaborlaw.com/largest-sexual-harassment-verdict-in-history-168-million/> (last visited Oct. 4, 2019). *See also* *Chopourian v. Catholic Healthcare West*, No. CIV S-09-2972, 2012 WL 1551728 (E.D. Cal. 2012).

54. Lee, *supra* note 53.

55. Gosfield, *supra* note 52, at *4.

56. Fibuch & Robertson, *supra* note 8.

57. *Id.*

clear and precise language and contain a well-defined due process clause with an appeal process. In turn, each physician should be asked to read and sign the document indicating an understanding of the rules.⁵⁸

A number of hospitals publish these rules under the category of “professionalism,” and mandate that physicians exhibit a minimum level of acceptable behavior towards co-workers and patients. Any violation of the rules may act as support for starting disciplinary action to address the conduct.⁵⁹ While differences in language and procedures among health care facilities is expected, common elements, include: Clearly explained behaviors that are expected; The repercussions for deviation from these behaviors should be explained in detail; Penalties should be staggered according to the severity of the incident; Those who commit repeat violations will be treated more harshly; and Every incident must be reported and documented.⁶⁰

This plan of action helps foster a positive atmosphere within the organization and members of the team are put on notice as to what is expected of them in the workplace.⁶¹

Discipline against a disruptive physician, however, can result in retaliation by the offender, especially if the doctor’s hospital privileges are suspended.⁶² A key event in this regard occurred in 1988 when the United States Supreme Court decided *Patrick v. Burget*.⁶³ This matter involved whether Oregon law protected physicians against federal antitrust liability as the result of their serving on a peer-review committee.⁶⁴ The facts reveal that the plaintiff declined an invitation by the defendants to join their surgical practice.⁶⁵ Instead, the plaintiff opened his own clinic but experienced problems in his dealings with the defendants.⁶⁶ The dispute escalated into a peer-review proceeding to terminate the plaintiff’s hospital privileges at the

58. *Id.*

59. Santin & Kaups, *supra* note 17, at 3.

60. *Id.*

61. Fibuch & Robertson, *supra* note 8.

62. *See* Hein-Muniz v. Aiken Reg’l Med. Ctr., 905 F. Supp. 2d 729 (D.S.C. 2012).

63. *Patrick v. Burget*, 486 U.S. 94 (1988).

64. *Id.* at 95–96.

65. *Id.* at 96.

66. *Id.*

city's only hospital on the ground that his care of patients was below the hospital's standards.⁶⁷

The plaintiff filed a federal lawsuit claiming violations of the Sherman Act by the defendant's charges and by their participating in the peer-review proceeding in order to reduce competition from the plaintiff rather than to improve patient care.⁶⁸ The Supreme Court ruled that the state's law failed to shield the defendants from liability for their activities on the hospital peer-review committee.⁶⁹ This ruling prompted Congress to enact the Health Care Quality Improvement Act of 1986.⁷⁰ The legislature found that the threat of money damages under Federal law unreasonably dissuaded doctors from serving on professional peer review committees. Therefore, there is a national overriding interest to protect physicians who serve in this capacity.⁷¹

This statute offers immunity under Federal and State laws to those on a peer review body who act in the reasonable belief that their action was in the furtherance of quality health care, and they act after a reasonable effort to obtain the facts even though their actions adversely impact the clinical privileges or professional society membership of a physician.⁷² This statute sets forth the specific requirements and standards for immunity and applies to disruptive physician cases.⁷³ Only a good faith review qualifies for immunity, so whether the standards are followed by the peer review committee is very important to the final disposition of most disruptive physician cases and is the subject of much litigation.⁷⁴

It must be noted, however, that the Act only grants immunity to "professional review actions."⁷⁵ This is defined as an action or recommendation by the professional review body which is done during a review activity, that is premised on the competence or professional actions of a doctor, and which may

67. *Id.* at 97.

68. *Id.* at 97–98.

69. *Patrick*, 486 U.S. at 105.

70. Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 (2019).

71. *Id.*

72. *Id.*

73. Erwin, *supra* note 5, at 281–80.

74. *Id.* at 280.

75. Gosfield, *supra* note 52, at *1.

adversely affect the clinical privileges of the physician.⁷⁶

VI. Court Action

Being labeled a disruptive physician, especially if sanctions are imposed, can have serious professional implications including the loss of one's hospital privileges. In fact, it can have career ending repercussions. State and federal agencies can also discipline a physician who is labeled disruptive if the offending conduct is determined to influence the quality of patient care or if it implies moral, ethical, or unprofessional deficiencies.⁷⁷ Unhappy patients can register a complaint with the health plan or managed health care firm triggering an investigation that can cause the loss of a physician's affiliation with the plan or hospital. Intimating and unprofessional conduct can also be reported to the National Practitioner Data Bank, thereby resulting in other investigations and charges against the physician who seeks a hospital affiliation or credentialing.⁷⁸

This data bank⁷⁹ maintains a listing of actions taken by authorized organizations regarding health care practitioners, entities, providers, and suppliers who do not meet professional standards. These adverse reports are permanently kept unless modified or removed by the entity that submitted them.⁸⁰ In turn, the information can be used in rendering decisions dealing with licensure, employment, contracting, membership or clinical privileges, or when conducting investigations. Under the appropriate circumstances, the information may even be obtained by plaintiff's counsel.⁸¹ Therefore, it is not surprising that litigation involving being labeled a disruptive physician is

76. Standards for Professional Review Actions, 42 U.S.C. § 11112(a) (2019).

77. WEISS, ZARETT, BROFMAN, SONNIENKLAR, & LEVY, P.C., *How the Title of Disruptive Physician Can Ruin Your Career and How to Avoid It, Firm News & Legal Alerts* (Aug. 1, 2010), https://weisszarett.com/lawyer/2010/08/01/Healthcare-Law/How-the-Title-of-%E2%80%9CDisruptive-Physician%E2%80%9D-Can-Ruin-Your-Career-and-How-to-Avoid-It_bl31980.htm.

78. *Id.*

79. *What You Must Report to the NPDB*, NATIONAL PRACTITIONER DATA BASE, <https://www.npdb.hrsa.gov/hcorg/whatYouMustReportToTheDataBank.jsp> (last visited Oct. 8, 2019).

80. *Id.*

81. *Id.*

common.⁸²

A Westlaw search of the phrase “disruptive physician” references 1,566 federal and state cases.⁸³ Not all of the cases, however, are relevant. For instances, some deal with whether a physician’s disruptive conduct constitutes a mental condition,⁸⁴ or whether a fee shifting provision of a hospital contract is in violation of public policy. Relevant cases deal with such issues as the removal of sanctions or the recovery of money for lost income, restraint of trade, or emotional harm.⁸⁵ Overall, the applicable cases involve the failure of the health care provider to follow process, discrimination claims, retaliation, or intent to harm cases.⁸⁶

An analysis shows that the courts do not care about actual quality issues, and they will usually not question the opinion of the hospital’s management team or the peer review committee.⁸⁷ In fact, the courts tend to favor the medical organization⁸⁸ on the basis of the granting of immunity under the Health Care Quality Improvement Act, affording deference when hospitals adhere to their bylaws or rules, or finding that disruptive behavior by itself is a proper justification to sanction a physician.⁸⁹ This bias in

82. Most disruptive physician cases are resolved without court intervention. Rosenstein, *supra* note 26, at 46.

83. This Westlaw search was conducted on Oct. 9, 2019.

84. *See Neravetla v. Dep’t of Health*, 394 P.3d 1028 (Wash. Ct. App. 2017).

85. *See Sternberg v. Nanticoke Mem’l Hosp., Inc.*, 62 A.3d 1212 (Del. 2013).

86. Rosenstein, *supra* note 26, at 49.

87. *See Ross Zbar et. al., The Disruptive Physician: Righteous Maverick or Dangerous Pariah?*, 124 PLASTIC & RECONSTRUCTIVE SURGERY 409 (2009).

88. *Id.*

89. Erwin, *supra* note 5, at 281. *See Sosa v. Board of Managers of Val Verde Mem’l Hosp.*, 437 F.2d 173, 177 (5th Cir. 1971). As noted:

No court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance. The court is charged with the narrow

favor of a hospital is partially based upon the court's reluctance to interfere with a hospital's decision to revoke, suspend, restrict, or to refuse to renew the clinical privileges of a medical staff member. Court review is usually limited to making sure that there is substantial adherence with the facility's bylaws concerning such a decision, and to ensuring that the bylaws provide rudimentary notice, a fair procedure, and an impartial tribunal.⁹⁰ This analysis is buttressed by the AMA, which notes that most lawsuits attacking a peer review proceeding should be dismissed at the summary motion phase. The litigation should only proceed when the physician has rebutted the presumption that the peer review process was reasonable and fair.⁹¹

The following is a representation of some of the cases under various categories.

A. Immunity under the Healthcare Quality Improvement Act (HCQIA)

Courts started finding health care facilities responsible for the inappropriate conduct of their medical staff under a corporate negligence theory for hiring and supervision in the mid-1960's. The basis for this liability is that patients depend upon the hospital to guarantee the quality of care afforded at its

responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered. In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere.

Sosa, 437 F.2d at 177.

90. *Mahmoodian v. United Hospital Center, Inc.*, 404 S.E.2d 750, 755 (W. Va. 1991). *See also* *Shulman v. Wash. Hosp. Ctr.*, 222 F. Supp. 59, 64 (D.D.C. 1963); *Eidelson v. Archer*, 645 P.2d 171, 175 (Alaska 1982); *Gaenslen v. Bd. of Dir.*, 232 Cal. Rptr. 239, 241-42 (Cal. Ct. App. 1985); *Gianetti v. Norwalk Hosp.*, 557 A.2d 1249, 1254-56 (Conn. 1989); *Adkins v. Sarah Bush Lincoln Health Center*, 544 N.E.2d 733, 737-41 (Ill. 1989); *Pepple v. Parkview Mem'l Hosp., Inc.*, 536 N.E.2d 274, 276 (Ind. 1989); *Porter Mem'l Hosp. v. Malak*, 484 N.E.2d 54, 61 (Ind. Ct. App. 1985); *State ex rel. Willman v. St. Joseph Hosp.*, 684 S.W.2d 408, 411-12 (Mo. Ct. App. 1984); *Gotsis v. Lorain Cmty. Hosp.*, 345 N.E.2d 641 (Ohio Ct. App. 1974); *Miller v. Indiana Hosp.*, 419 A.2d 1191, 1193-94, 1196 (Pa. Super. Ct. 1980), *appeal denied* (Pa. Oct. 1, 1980).

91. *Grogan & Knechtges*, *supra* note 4, at *3.

facility.⁹² To succeed on such a claim, however, the plaintiff must prove that the hospital knew or should have known of the doctor's negligent conduct.⁹³

This potential liability has motivated a number of state legislatures to enact peer review laws.⁹⁴ A peer review is the way by which healthcare management examines the quality of medical treatment provided by physicians under their charge. This undertaking has been approved by different states who have enacted statutes to protect the privacy of the materials created during the peer review process.⁹⁵ Likewise, Congress appreciated the need for effective peer review, as well as a procedure to encourage doctors to participate.⁹⁶ This led to the enactment of the Immunity under the Healthcare Quality Improvement Act of 1986 (HCQIA) in which Congress bestowed qualified immunity from liability for peer review participation to doctors and dentists as well as establishing a national practitioner data bank to keep track of inept, incompetent, or unprofessional physicians. The legislation also established procedural rules for due process, privilege restrictions, and reporting requirements.⁹⁷

HCQIA has generated much litigation by disgruntled physicians who wish to sue the peer review committee that disciplined them as well as the whistleblowers who reported the disruptive physician. The seminal case is *Meyers v. Columbia/HCA Healthcare Corporation*,⁹⁸ and this opinion is frequently referenced in many subsequent decisions.⁹⁹ The facts reveal that Dr. Meyers filed a lawsuit because he was denied

92. Peters, *supra* note 30, at 8.

93. *Id.*

94. *Id.*

95. David Freedman, *The Healthcare Quality Improvement Act of 1986*, RELIAS MEDIA (May 1, 1999), <https://www.reliasmedia.com/articles/41639-the-health-care-quality-improvement-act-of-1986>.

96. *Id.*

97. Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, AM. J. L. & MED. 453, 455 (1990).

98. *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461 (6th Cir. 2003).

99. Mark W. Leach, *Dealing With Disruptive Physicians: The Myers Cases and Their Progeny*, 9 AM. HEALTH. L. ASS'N. 1, 1 (Oct. 2010), (http://www.postschell.com/site/files/medstaffnews_oct10.pdf). According to Westlaw, the Myers decision has been referenced in 419 other decisions.

reappointment to the hospital's medical staff over concerns about his disruptive conduct.¹⁰⁰ A hospital committee determined that the physician displayed repeated temper tantrums, he refused to limit elective cases to the time period assigned, he attempted to interfere with the right of an attending physician to refer a patient to the surgeon of his choice, he was condescending towards women, he refused to speak to members of the surgical team during a procedure, and he demonstrated several instances of throwing a scalpel during an operation.¹⁰¹ The committee believed that this conduct could adversely affect the quality of patient care and so informed the doctor. Dr. Meyers requested a hearing and the board appointed a peer review committee consisting of a retired appeals judge, an attorney, a bank president, an industrialist, and dentist even though the bylaws noted that three people from the medical staff should be on the committee when "feasible."¹⁰² The committee met on eleven occasions and voted not to appoint Dr. Meyers to the staff.

This prompted the physician to file a lawsuit in state court seeking an injunction forcing the hospital to reappoint him. The court refused to reinstate his privileges so the doctor filed a different lawsuit in federal court for violating the federal antitrust laws and breach of the covenant of good faith.¹⁰³ In ruling in favor of the hospital, the court noted that HCQIA was enacted to allow for effective peer review, motoring of incompetent physicians, and to offer qualified immunity from damages for those who participate in peer review duties.¹⁰⁴ This immunity will be granted as long as the review is performed in the reasonable belief that the action was in furtherance of quality health care; after a reasonable effort to learn the facts is undertaken; the physician is given adequate notice and hearing procedures; and in the reasonable belief that the action was needed after a reasonable investigation.¹⁰⁵ Compliance with these requirements provides a rebuttable presumption of immunity, thereby forcing the physician to prove that the

100. *Meyers*, 341 F.3d at 463.

101. *Id.* at 464–65.

102. *Id.* at 465.

103. *Id.* at 466.

104. *Id.* at 467.

105. *Id.*

hospital did not comply with the standards.¹⁰⁶ In this matter, the court determined that the doctor received adequate notice of the hearing, and the committee only had to consist of hospital staff when “feasible.” It was not possible to appoint staff members to the committee in this case because they were working too many hours and could not devote the time to a hearing.¹⁰⁷

Isaiah v. WHMS Braddock Hospital Corp. involved a determination by the hospital to suspend the plaintiff’s hospital privileges.¹⁰⁸ The surgeon was granted conditional privileges upon his completion of a proctoring program. This remedial action was recommended in view of several “red flags” that the Chair of the Department of Surgery saw in the records dealing with the plaintiff’s length of operations, surgical judgment, decision making, ability to identify anatomy, and case selection.¹⁰⁹ Following an investigation, the plaintiff’s hospital privileges were summarily suspended based upon the hospital’s bylaws that allowed precautionary suspensions when “the activities or professional conduct of any Medical Staff Appointee are considered to be a departure from the standard of the Medical Staff or the Hospital.”¹¹⁰

The Medical Events Subcommittee then convened, met with the plaintiff, and discussed the precautionary suspension. The end result was that the Subcommittee reached the conclusion “that [Dr. Isaiah’s] surgical competence and clinical decision-making is below the standards of the hospital.”¹¹¹ The Medical Executive Committee and Board of Trustees also concluded that all privileges should be revoked. The surgeon was then afforded a full hearing at which time the original decision was upheld and the National Practitioner’s Data Bank was notified of the action.¹¹²

The plaintiff instituted a lawsuit on a number of grounds including defamation, invasion of privacy, and tortious inference

106. *Meyers*, 341 F.3d at 467–68.

107. *Id.* at 470.

108. *Isaiah v. WHMS Braddock Hosp. Corp.*, No. JFM 07-2197, 2008 U.S. Dist. LEXIS 57850 at *1 (D. Md. July 25, 2008).

109. *Id.*

110. *Id.* at *8.

111. *Id.* at *12.

112. *Id.* at *19.

with prospective advantage.¹¹³ The defense filed a motion for summary judgment claiming immunity under the Health Care Quality Improvement Act. The physician countered that the defendants were not immune because he had offered adequate evidence for a jury to conclude that the defendants failed to act appropriately with respect to the prongs of the immunity analysis.¹¹⁴

In dismissing the claim, the court noted that the immunity inquiry does not mandate that the court find that the surgeon actually made a mistake, breached a standard of care, or put a patient in danger. Rather, all that is mandated is a determination that the hospital possessed a reasonable belief that the action taken would advance the objective of quality health care. Thus, an incorrect but reasonable determination would still be afforded immunity.¹¹⁵

Sherr v. Health East Care System offers another example of how far the courts will go to protect peer review committees.¹¹⁶ Sherr was a neurosurgeon who had hospital privileges at two related institutions. He filed a lawsuit against the hospitals claiming that their in-house neurosurgeons sought his ouster as a competitor by defaming his medical skills and arranging a sham peer review process that caused his summary suspension.¹¹⁷ The facts show that the defendants have a Spine Council that reviews spinal care matters, and they hold monthly meetings to talk about problem cases. One of the hospital's physicians referred patients to neurosurgeons who were not part of the in-house team, including the plaintiff. This practice resulted in the referring physician being berated especially when he referred matters to the plaintiff who they labeled "a hack," "not a good surgeon," and an "asshole."¹¹⁸

Contemporaneously, one of the hospital's operating room staff, an infection prevention specialist, expressed concern about the plaintiff's increased infection rates, blood loss, and redo procedures. A red flag was also raised by a Spine Quality Report discussing Dr. Sherr's increased rate of infection following fusion

113. *Id.* at *20.

114. *Isaiah*, 2008 U.S. Dist. LEXIS 57850, at *20–21.

115. *Id.* at *49–50.

116. *Sherr v. Health East Care Sys.*, 262 F. Supp.3d 869 (D. Minn. 2017).

117. *Id.* at *1–2.

118. *Id.* at *8.

surgery.¹¹⁹ This caused one of the in-house neurosurgeons to contact the head of surgery about the issue. The plaintiff was then notified that a peer review would be undertaken at which time the in-house neurosurgeon provided the committee with a summary of the data from the Spine Quality Report which showed that Dr. Sherr's infection rate was more than double that of the other surgeons.¹²⁰ The Committee immediately issued a summary suspension of Dr. Sherr's privileges out of concern for patient safety. The Medical Executive Committee then meet to discuss the suspension, and Dr. Sherr objected to the inclusion of the in-house neurosurgeon's presence on the Executive Committee based upon her status as a competitor. After deliberating, the Committee upheld the suspension. A hearing was subsequently held at the request of the plaintiff before the Judicial Review Committee and the suspension was overturned.¹²¹ Nevertheless, Dr. Sherr did not seek reinstatement and moved to Florida where he entered into an employment agreement with another practice.¹²²

Dr. Sherr filed a lawsuit, and the defendants argued that their peer review activities were immune under state and federal law.¹²³ The court noted that immunity applies unless the peer review process is motivated by malice towards the subject of the review. Dr. Sherr argued that the peer review process was started by the in-house neurosurgeon who was a competitor and had a direct economic stake in the outcome.¹²⁴ The court dismissed this argument and stated that both state and federal peer review statutes "contain no provision barring competitors from participating in professional review activities."¹²⁵ Because the plaintiff failed to offer evidence from which a reasonable juror could determine that the peer review process was motivated by malice, the committee was immune from a lawsuit.¹²⁶ Interestingly, the court noted that a reviewer's

119. *Id.* at *9.

120. *Id.* at *9–10.

121. *Id.* at *20–21.

122. *Sherr*, 262 F. Supp. 3d at 878.

123. *Id.* at *23.

124. *Id.* at *24.

125. *Id.* at *27–28.

126. *Id.* at *32.

subjective bias or bad faith is not relevant.¹²⁷

The opposite result was reached in *Islami v. Covenant Medical Center, Inc.*, where the court ruled against a hospital because it did not believe the defendant was entitled to summary judgment on the basis of HCQIA immunity.¹²⁸ The defendant failed to provide the physician with notice and hearing procedures as outlined in the bylaws and under the terms of the statute.¹²⁹

B. Reliance upon Bylaws and Procedures

The majority of courts hold that medical staff bylaws are enforceable contracts between the hospital and physician.¹³⁰ These rules generally explain who can trigger an investigation or request remedial action. If such an investigation uncovers a doctor with shortcomings, restrictive measures may be levied to bring about improvement in the offending conduct, including the suspension of a physician's hospital privileges.¹³¹

The courts are disposed to rule in favor of hospitals against lawsuits by disruptive physicians if the peer review committee adheres to the process set forth in the bylaws or the rules and

127. *Id.* at *33.

128. *Islami v. Covenant Med. Ctr.*, 822 F. Supp. 1361 (N. D. Iowa 1992).

129. *Id.* at 1377. In *Rosenhek v. Windsor Regional Hospital* 2010 ONCA 13 (2007), aff'g O.J. 44856; leave to appeal to the Supreme Court of Canada refused, S.C.C.A. No. 89 (2010), a court in Ontario, Canada awarded an alleged disruptive physician whose hospital privileges had been revoked in bad faith over \$3 million. The court found that the hospital had revoked his privileges because the doctor did not "fit in." Shantona Chaudhury, *Disruptive Physician Behavior and Hospital Liability in Tort: Rosenhek v. Windsor Regional Hospital*, PAPE CHAUDHURY (March 2011), <https://papechaudhury.com/disruptive-physician-behaviour-and-hospital-liability-in-tort-rosenhek-v-windsor-regional-hospital/>.

130. See *Lewisburg Community Hosp. v. Alfredson*, 805 S.W.2d 756, 759 (Tenn. 1991); *Pariser v. Christian Health Care Sys.*, 816 F.2d 1248, 1251 (8th Cir. 1987); *Posner v. Lankenau Hosp.*, 645 F. Supp. 1102, 1106 (E.D.Pa.1986); *Terre Haute Regional Hosp. v. El-Issa*, 470 N.E.2d 1371 (Ind. App. 1984); *Anne Arundel General Hosp. v. O'Brien*, 432 A.2d 483 (1981); *St. John's Hosp. Med. Staff v. St. John Regional Med. Center*, N.W.2d 472, 474–75 (1976); *Joseph v. Passaic Hosp. Ass'n*, A.2d 18 (1958). For examples of courts who have found that bylaws do not constitute a contract, see *Munoz v. Flower Hosp.*, 507 N.E.2d 360 (1985); *Todd v. Physicians & Surgeons Comm. Hosp.*, S.E.2d 378 (1983); *Stein v. Tri-City Hosp. Authority*, 384 S.E.2d 430 (1989); see also 41 C.J.S. Hospitals § 16 (1991).

131. See *Yedidag v. Roswell Clinic Corp.*, 346 P.3d 1136 (N.M. 2015).

procedures.¹³² In fact, the immunity granted by the Health Care Quality Improvement Act is not dependent upon strict compliance with a hospital's bylaws, although the statute does include a "safe harbor" provision.¹³³ If the procedure used by a hospital to handle a dispute varies from the letter of its bylaws, the facility will still satisfy the immunity requirements if it is "fair to the physician under the circumstances."¹³⁴

*Leach v. Jefferson Parish Hospital District No. 2*¹³⁵ involved a physician who was summarily suspended after continued disruptive behavior.¹³⁶ In turn, the plaintiff asked the Medical Executive Committee to lift his summary suspension. The chief of staff replied that the bylaws failed to contain a review process once a suspension had been upheld by the Board of Directors. Dr. Leach, however, was informed that the hospital had a long-standing policy that mandated a one-year moratorium before a physician could reapply for staff membership.¹³⁷ While the bylaws did not mandate such a moratorium, the hospital's handbook recommended reapplication after a minimum of one year. This prompted the suspended physician to file the instant lawsuit claiming that his due process rights were violated.¹³⁸

The Court determined that the hospital reasonably adhered to its rules, so the plaintiff's claim was dismissed. While the hospital's bylaws offered no guidance for reapplication after a summary suspension, the Committee Handbook recommended a one-year moratorium. It was noted that the hospital has an obligation to protect patients and to guarantee their competent treatment.¹³⁹ Therefore, the measures used by the hospital were reasonable. As for the argument that the hospital's rules and regulations were inadequate to protect the doctor's constitutional rights, Dr. Leach's interest in his medical privileges were protected because he could have practiced at another hospital. There was also no evidence that the Executive

132. Erwin, *supra* note 5.

133. *Wieters v. Roper Hosp., Inc.*, 58 F. App'x 40, 46 (4th Cir. 2003).

134. *Id.* at 46.

135. *Leach v. Jefferson Par. Hosp. Dist. No. 2*, 870 F.2d 300 (5th Cir. 1989).

136. *Id.* at 301.

137. *Id.* at 302.

138. *Id.*

139. *Id.*

Committee failed to provide him with the necessary safeguards to protect his interests at the hearing.¹⁴⁰ Lastly, the hospital has an obligation to offer quality medical care to its patients. If a doctor is disruptive or has personal issues, the health care facility has an obligation to step in. The suspension was necessary in this case, so the procedural safeguards to guarantee that the plaintiff's constitutional rights were protected were adequate.¹⁴¹

On the other hand, the need to follow the bylaws is not always required. In *Taylor v. Kennestone Hospital, Inc.*,¹⁴² an anesthesiologist was accused of sexually harassing a nurse. During an investigation, it was learned that the physician demonstrated harassing conduct toward others, such as inappropriate gestures and remarks, offensive touching, and lewd suggestions. Several staff members even said that they were afraid to work when the doctor was on duty.¹⁴³ The plaintiff was confronted with these allegations, and he admitted to a sexual harassment problem. Faced with possible disciplinary action, the doctor gave up his staff privileges, and sought treatment with a psychiatrist.¹⁴⁴ The hospital continued its investigation and uncovered even more instances of inappropriate conduct. An accommodation was worked out where the doctor could see patients at the hospital so long as he adhered to the guidelines created by his psychiatrist. The doctor was warned, however, that any other inappropriate conduct, or his failure to adhere with his psychiatrist's treatment plan, could result in "suspension, termination or restriction of his clinical privileges."¹⁴⁵ Subsequently, the physician applied for reinstatement, but it was determined that he had not complied with the plan established by the psychiatrist. His application was denied, and the plaintiff requested a hearing. The hearing panel recommended that the physician be reappointed to the medical staff for three months upon proof from the psychiatrist certifying compliance with the plan.¹⁴⁶ The Board of Trustees, however, rejected this recommendation and denied Taylor's

140. *Id.* at 303.

141. *Leach*, 870 F.2d at 303.

142. *Taylor v. Kennestone Hosp., Inc.*, 596 S.E.2d 179 (Ga. Ct. App. 2004).

143. *Id.* at 181.

144. *Id.* at 182.

145. *Id.*

146. *Id.*

application for reappointment.

A lawsuit was filed, and the doctor maintained that he did not receive proper notice of the various proceedings which violated the defendant's bylaws. The Court granted the defendant's motion for summary judgment based upon the immunity provided by HCQIA. It noted that the statute did not require that hearing procedures satisfy a hospital's bylaws in order for immunity to apply. Rather, the statute merely requires that the procedures of the hearing be adequate and fair under the circumstances.¹⁴⁷

C. Disruptive Conduct as Justification for Suspension

A medical facility has the obligation to make sure that physicians appointed to its staff satisfy particular requirements of professional competence and conduct, so long as there is a sufficient connection between those standards and the hospital's duty of offering quality patient care.¹⁴⁸ This standard of care has led a number of courts to determine that disruptive conduct by itself is proper justification for a health care facility's determination to suspend or terminate a physician's staff privileges.¹⁴⁹ As noted in *Mahmoodian v. United Hospital Center, Inc.*, disruptive behavior is a legitimate concern to a hospital in formulating medical staffing decisions. Nearly all courts examining the problem have, therefore, concluded that a hospital may adopt and enforce bylaws providing for the suspension or revocation of clinical privileges of the offending doctor, solely when such conduct may have an adverse impact upon the patient's quality of care.¹⁵⁰ This determination will be based upon an objective test which focuses on the totality of the circumstances,¹⁵¹ but the test does not mandate that the peer review decision be correct or that the determination actually improves the quality of care.¹⁵²

147. *Id.* at 185.

148. *Mahmoodian v. United Hosp. Center, Inc.*, 404 S.E.2d 750, 759 (W. Va. 1991).

149. Erwin, *supra* note 5, at 277-78.

150. *Mahmoodian*, 404 S.E. 2d at 760.

151. *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994).

152. *Id.*

The caveat that the imposition of sanctions must relate to the patient's quality of care is important to keep in mind. This is demonstrated by *Clark v. Columbia/HCA Information Services* where the court refused to grant immunity to a hospital who had revoked the privileges of a psychiatrist because their determination was not in furtherance of quality health care.¹⁵³ Clark, a child psychiatrist, enjoyed hospital privileges at West Will Hospital. This facility alleged that the plaintiff was engaging in "activities or professional conduct which are disruptive to Hospital operations" so they conducted a peer review.¹⁵⁴ The board determined that Clark had engaged in disruptive conduct that harmed the quality of health care so he was suspended. The plaintiff instituted a lawsuit against the hospital claiming that the hospital "conspired to commit illegal conduct, divert patients away from him, and improperly terminated his staff privilege."¹⁵⁵ He also asserted that his privileges were ended because he reported violations of medical standards, an action that is protected as a matter of public policy.¹⁵⁶

The Court allowed the lawsuit to proceed because the plaintiff had shown by a preponderance of the evidence that the revocation of his hospital privileges was not premised upon a reasonable belief that it was in furtherance of quality health care. The Court determined that his suspension related exclusively to the plaintiff's reports and letters to outside doctors and regulatory agencies, complaining about the care and procedures the defendant used in its child psychiatric practice, the scheduling of doctors, and in-patient insurance policies.¹⁵⁷ The doctor's actions constituted protected whistleblowing conduct which cannot be reasonably classified as limiting incompetent actions or protecting patients.¹⁵⁸

Another challenge facing the alleged disruptive physician who fights disciplinary action is the awarding of attorney's fees to the hospital; *Sternberg v. Naticoke Memorial Hospital, Inc.*

153. *Clark v. Columbia/HCA Info. Servs. Inc.*, 25 P.3d 215 (Nev. 2001).

154. *Id.* at 218.

155. *Id.* at 219.

156. *Id.* at 220–21.

157. *Id.* at 222–23.

158. *Id.* at 223.

provides an example.¹⁵⁹ The plaintiff sued the hospital due to the precautionary suspension of his clinical privileges. The facts demonstrated that the physician was critical of the hospital's practices and was often vocal about quality of care issues. The way that he articulated his opinions and dealing with the staff, however, was disruptive and put patients at risk.¹⁶⁰ The plaintiff did not succeed on his challenge to overturn the suspension and he was presented with a \$412,928 bill for legal services incurred by the hospital in defense of the lawsuit. The hospital's bylaws provided that if "an individual institutes legal action and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees."¹⁶¹ Sternberg asserted that the legislature found that an award of attorney's fees should be restricted in HCQIA immunity cases to those that are frivolous, unreasonable, without foundation, or instituted in bad faith.¹⁶² The court disagreed and found that the counsel fee provision contained in the bylaws applied and was not against public policy.¹⁶³

VII. Conclusion

A disruptive physician can cause havoc in the work place and compromise patient safety. While the issue was once swept under the rug, this is no longer the case. Troublesome conduct is now an area of primary concern among health care providers, and it is often discussed in the hospital's bylaws or rules and regulations. Offending physicians can face prompt suspension or revocation of their hospital privileges, a decision that has lasting implications.

State and federal legislatures have recognized the need to protect peer review committees so they have been granted qualified immunity for their actions. In turn, court review of physician discipline is very limited and the judiciary tends to favor the medical organization as long as the basic tenants of

159. Sternberg v. Naticoke Mem'l Hosp., Inc., 62 A.3d. 1212 (Del. 2013).

160. *Id.*

161. *Id.* at 1216.

162. *Id.*

163. *Id.* at 1221.

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due process have been followed.