

CALIFORNIA ASSOCIATION MEDICAL STAFF SERVICES

Redwood Empire Chapter

Codes of Conduct and Medical Staff Peer Review: Beware of Incompatibility

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Introduction.

The medical staff bylaws, or medical staff rules and regulations, for most medical staffs describe an investigatory process that not only follows a particular logic but takes into account the experience of, at least, the past fifty years of medical staff peer review. More recently, other organizations have become interested in the procedures followed by medical staffs as they monitor the practices and professional conduct of physicians. This has, understandably but sometimes unhelpfully, led these other organizations to prescribe investigatory procedures that are not always fully compatible with traditional medical staff processes.

Most recently, the Joint Commission has weighed in, issuing a July 9, 2008 “Sentinel Event Alert” calling attention to the potential harm to patient care that might be caused by disruptive physician behavior. Then, building upon that, the Joint Commission suggests certain investigatory procedures, taking the form of a “code of conduct.”

Medical staff leaders and medical staff services professionals should review these Joint Commission prescriptions with particular care, in order to assure that any “code of conduct” adopted in response does not clash with established medical staff investigatory processes.

And, the recent court case that is described toward the end of this presentation was spawned by a medical staff investigation into complaints of disruptive behavior by a physician that, as best as one can tell, closely resembled the types of investigations that are typical and entirely appropriate within medical staffs throughout this State.

1. Standard and traditional medical staff investigatory processes.

- Presentation of concerns to medical staff officers and departmental leaders.
- The informal departmental investigation.
- The formal medical staff corrective action investigation.

2. Key attributes of the medical staff investigatory process.

- The informal meeting with the concerned physician.
- The commitment to confidentiality and the carefully defined role of the “complainant.”
- The issuance of a corrective action recommendation that is guided by a commitment to patient care above all else.

3. Notable recent prescriptions of the Joint Commission.

- The Joint Commission has now made clear that hospitals and medical staffs must have detailed and meaningful “codes of conduct” in place by January 1, 2009. In this regard, a “code of conduct” is defined as one that describes acceptable behavior, specifically defines impermissible “disruptive behavior,” and prescribes certain investigatory procedures. Therein lies the challenge, and the potential for confusion.
- Consequently, the significance of “disruptive behavior” now not only takes into account its negative impact upon patient care, and its corrosive affect upon medical staff operations, but also its potential threat to hospital accreditation and, as a potential consequence, Medicare payment.
- More specifically, the July 9, 2008 “Sentinel Event Alert” provides in pertinent part:

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01) that addresses disruptive and inappropriate behaviors in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

...

Other Joint Commissions suggested actions

1. Educate all team members - both physicians and non-physician staff - on appropriate professional behavior defined by the organization’s code of conduct. . . .

...

3. Develop and implement policies and procedures/processes appropriate for the organization that address:

...

How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).

- This Sentinel Event Alert builds on a series of Joint Commission pronouncements in

the relatively recent past. For example, in 2006 the Joint Commission issued draft “National Patient Safety Goals,” and Goal 16 was: “Discourage disruptive behavior.”

- This then led to “Requirement 16A,” which was:

“Organizations have guidelines for acceptable behaviors to identify, report and manage behaviors that cause disruption to patient safety.”

- And, this introduced “Implementation Expectations for 16A,” which included:

1. The organization develops a code of behavior which is embraced by the organization’s governance, management, and medical and clinical leadership.

...

3. The organization encourages staff to report instances of disruptive behavior without fear of retribution.

...

5. Processes are implemented . . . to manage unacceptable behavior.”

- Therefore, the July 9, 2008 “Sentinel Event Alert” should surprise no one.

4. The potential for inconsistent action.

In the course of preparing for and implementing the steps mandated by this latest Joint Commission “Sentinel Event Alert” and directive, the following should be carefully noted:

- This “Sentinel Event Alert” might be viewed as nothing more than a welcome affirmation of the need that we all sense to take effective action in response to disruptive behavior by physicians and others. However, it also carries with it the seeds for confusion and inconsistent, and ultimately debilitating, action.
- In spite of the suggestion that “disruptive behavior” warrants an investigatory process and progressive disciplinary procedure that are unique, separate, and apart from all other forms of corrective action, the Medical Staff and Hospital should make sure that the procedures adopted for dealing with “disruptive behavior” or “unprofessional conduct” in any “code of conduct” are always described as guidelines, not exclusive procedures and not mandatory steps.
- The adopted procedures should recognize that, in the end, no effective action can be

taken against a physician's privileges or appointment to the Medical Staff unless the corrective action process or reappointment process prescribed by the Medical Staff Bylaws is followed.

- In fact, there is no clear dividing line, and there may be almost a complete overlap, between “disruptive behavior” or “unprofessional conduct” and actual or potential poor patient care. This is to say that the behavior that might be viewed as disruptive or unprofessional is also behavior that causes, or at least accompanies, poor patient care.
- While this might be viewed as nothing more than a statement of the obvious, with no particular practical impact, it does become relevant for peer review purposes if a hospital and a medical staff have gone to the trouble of devising two separate and distinct peer review and corrective action investigatory procedures and disciplinary procedures for, on the one hand, poor patient care and, on the other hand, disruptive behavior.

5. The consequences of inconsistent action.

In re Peer Review Action, Minnesota Court of Appeals, Dakota County District Court (June 3, 2008): This decision warrants some discussion not because it is controlling upon California hospitals and medical staffs but because it is indicative of the manner in which the actions of well-intentioned hospital executives and medical staff leaders can be misinterpreted and become maddeningly confused once one arrives in court.

According to the opinion of the Court of Appeals, the Hospital and Medical Staff initiated an investigation in response to reports of a Medical Staff member's disruptive behavior. This step was taken in accord with the procedures prescribed by the Medical Staff Bylaws.

Accordingly, in this particular Medical Staff, the Credentials Committee was assigned that task, and the physician was invited to meet with the Credentials Committee to discuss matters of concern.

Following its investigation, the Committee recommended a suspension of privileges to last for 120 days. The recommendation was then submitted to the Medical Staff Executive Committee, which concurred with the finding that corrective action was warranted, and instead recommended that the suspension be increased to 180 days.

The physician then requested a Medical Staff hearing, and after a hearing the recommendation was sustained. That decision was then affirmed upon appeal to the Governing Body. The physician then commenced litigation, by which he sought a court order blocking implementation of the suspension of privileges.

The Court issued the requested injunction, based primarily upon the physician's argument that while the Medical Staff's corrective action process might have followed the procedures

described in the Medical Staff Bylaws, the investigation did not conform to the detailed process set forth in the “Hospital’s Disruptive/Abusive Behavior Policy.” The following excerpts from the Court’s opinion are notable:

- “A hospital’s peer review action is motivated by malice, for the purposes of . . . [State law] . . . , when a hospital disregards its own policies and intentionally and repeatedly violates a physician’s procedural rights when disciplining a physician through a peer review process (emphasis added).”
- “[The] Hospital’s Disruptive/Abusive Behavior (DAB) Policy sets out a detailed process for communication among administrators, medical staff leadership, and physicians regarding behavioral conflict. The DAB Policy entitles a physician under review to notice of any allegedly disruptive behavior, and an opportunity to modify that behavior and develop conflict- resolution skills. . . . [The] Hospital did not give Physician an opportunity to modify his behavior and develop conflict resolution skills”
- “Physician pointed out that the [Credentials] committee had not followed the DAB Policy, which calls for early and gradually increasing intervention. . . .”
- “Unlike HCQIA [the Health Care Quality Improvement Act of 1986, which is not applicable given the request for injunctive relief], . . . State immunity extends to injunctive relief. . . . However, a hospital forfeits its state law immunity if its peer review process was motivated by malice toward the subject of a peer review inquiry. . . .”
- “The district court [the trial court] reached its conclusion of malice on six findings:
 - (1) Hospital’s peer review process began outside hospital’s normal channels;
 - (2) Hospital began its investigation in contravention of the Hearing policy, which required that Hospital leadership meet with Physician to discuss his behavior before seeking discipline;
 - (3) Hospital conducted the investigation in a manner contrary to the DAB policy, which required Hospital to give physician an opportunity to correct his behavior before imposing discipline;
 - (4) in charging Physician, Hospital cited incidents that were unfairly old;
 - (5) Hospital treated Physician disparately as compared to other physicians subject to discipline”
- “Hospital argues that these findings, even taken as true, are insufficient to show

malice. But each of these procedural irregularities is significant, and taken together, they clearly demonstrate that Hospital intentionally, and repeatedly, violated its own established procedural safeguards. Because the District Court’s findings show that Hospital repeatedly disregarded several of its own policies without justification in disciplining Physician, those findings are sufficient to support the District Court’s conclusion that Hospital acted willfully in violating its own peer review procedures. That willfulness is malice. . . .” (emphasis added).

6. Conclusion.

The “code of conduct” you adopt in dutiful obedience to the directives of the Joint Commission may, in all of its detail, be taken by a court to describe the mandatory Medical Staff investigatory process that your Medical Staff must follow when reviewing physician behavior, no matter how simple and brief your readily understandable Medical Staff Bylaws corrective action article might be.

The usual Medical Staff Bylaws description of corrective action procedures will quite liberally provide that an investigation might be requested by any one of the number of Medical Staff officers, that the Medical Executive Committee has complete discretion to decide what committee or group will conduct the investigation, if any, and that the procedures to be followed during any investigation are largely left to the investigating committee.

To the contrary, almost any “code of conduct” will set forth, in detail, how the investigation begins, how minor a complaint is necessary to prompt an inquiry, how many days are allowed for completion of the review, when the physician is to be invited to a meeting, who must be present at the meeting, when the final report is to be issued, and how much or how little may be recommended at the end of the investigation, depending on how many comparable investigations preceded the current one.

In summary, every “code of conduct,” and every proclamation of “zero tolerance,” is not just a description of acceptable physician behavior, but also may be a “code of conduct,” and a rigid one at that, prescribing the process to be followed by the Medical Staff leadership in responding to concerns about physician behavior.