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DEALING WITH THE DISRUPTIVE PHYSICIAN

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Imagine you operate a fast food restaurant. You have an employee who excels at cooking french fries, but you find increasingly, she is throwing food at customers, groping male co-workers, and cussing with increasing regularity. Despite her ability to cook french fries, you find your other employees avoid her with regularity. As a matter of fact, three or four of the dishwashers have left your employment for reasons you suspect to be connected to the behavior of the french fryer. You have confronted her about her behavior, and she has informed you her outbursts are: 1) distorted and a product of the imagination of her coworkers; 2) the fault of incompetent co-workers (if she did not have to deal with such incompetence, she would not be so angry); 3) justified, because her french frying ability far exceeds that of any other french fry cooker in the world, and the restaurant will go out of business without her invaluable assistance; 4) exaggerated and her co-workers are too sensitive; or 5) necessary to the efficient function of the restaurant.

Now, assume the french fry cook is a physician. What are the differences? Are physicians in such short supply, they are afforded special treatment? Are there special rules that guarantee a physician's right to practice medicine? Should we avoid dealing with the physician because he or she is an intelligent person? Should we avoid conflict with the physician because he or she is wealthy and powerful?

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Is the process so complicated and full of trip wires and mine fields that dealing with the disruptive physician is nearly impossible? The purpose of this article is to examine the laws that govern how to deal with a disruptive physician in Wyoming, and to provide advice on how to resolve the problems they create.

I. DON'T DO IT. AND IF YOU THINK YOU CAN DO IT, DON'T DO IT.

An old proverb says an ounce of prevention is worth a pound of cure. Nowhere is this statement more applicable than in the recruitment and retention of physicians. Carefully checking the background of prospective physicians is the single most important step in protecting the collegiality, function, and operation of the medical staff. If a physician candidate has a history of an inability to get along with professors, other practitioners, administrators, nurses, staff, and the community, problems are looming in the future for you. If this inability to get along is the result of the practitioner's perceived view that all those around her are incompetent, and it was their incompetence which led to the breakdown in communication, an alarm should be sounding with respect to the credentialing of this candidate. If all of the problems in the candidate's life appear to be the fault of everyone except the practitioner, proceed with extreme caution. Leopards rarely change their spots. If a candidate has a history of discipline matters or lawsuits arising out of physician-patient interaction, or with other institutions, that candidate should receive additional scrutiny before recruitment to the community, or credentialing at your hospital.

A disruptive physician can be like a bad relative, who comes to your house and never leaves. When a candidate is recruited, or is seeking privileges, treat that candidate as if he or she is going to be around for the next thirty or forty years. Trust your judgment. When viewed in that time frame, if issues arise which create suspicions, pass on the candidate and continue searching until someone is found who could fill the position for the next three or four decades.

Conduct a thorough background check. Check not only the credentials and educational history of the practitioner, but interview his former co-workers and educators. Conduct thorough interviews with the practitioner. Conduct these steps with due diligence and as if the future of your organization depends on it. View the applicant with the same scrutiny as someone who wishes to court your child. Subject to the ADA concerns (which this article addresses later) if a history of disruptive behavior exists with the practitioner, never assume the behavior is reserved for history. Remember, personalities change when money is involved. If a practitioner becomes obstinate or unyielding in the negotiation of the recruitment or employment agreement; view that behavior as an indicator of future behavior. Trust your gut.

If there are indications the practitioner will not fit within your medical community, consider all of your options. The goal of bringing physicians into

your medical staff is to establish a long-term, committed relationship for the benefit of the community, and which is satisfactory to the other physicians, administration, the staff, and the governing body. A disruptive practitioner can destroy the harmony among all. Our advice is, do not ignore a practitioner's pattern of disruptive behavior in order to have him or her on your medical staff. Don't do it. Even if you think you can deal with the practitioner's behavior, just don't do it.

II. GET YOUR HOUSE IN ORDER

Before proceeding with an action against a disruptive practitioner, make sure the hospital's house is in order. If a hospital has noncompliant bylaws or policies, the noncompliance will be used as defenses to any peer review action, or worse, may give rise to a cause of action against the hospital for noncompliance with the law. Disruptive physician proceedings are usually acrimonious and often result in lawsuits against the hospital. The hospital should anticipate and prepare for adversarial proceedings prior to commencement of any action, so they do not receive traction later in the proceedings.

Peer review, as we presently know it, was a product of the Health Care Quality Improvement Act of 1986 which provided limited immunity from liability in damages to peer review participants and established a scheme for reporting physician disciplinary actions to a nationwide data bank.[1] The standards in §11112(a) require the professional review body to take review actions only with the reasonable belief that the action is in furtherance of quality health care, after reasonable efforts to obtain the facts, with the provision of adequate notice and hearing procedures, and only in the belief that such action is warranted by the facts.[2] If those standards are met, and the reporting requirements in §§ 11131-11137 are met, then the persons participating in the peer review process have immunity from damages in most circumstances.[3] No immunity is provided under federal or state civil right laws.[4]

Wyoming has codified the Health Care Quality Improvement Act in the Professional Standard Review Organizations Statutes.[5] The statutes provide for a medical peer review organization, and allow local, county or state medical societies to establish professional standard review organizations.[6] The act provides

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[1] Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152 (1986).

[2] 42 U.S.C. §11112(a) (1986).

[3] 42 U.S.C. §11111(a)(1) (1987).

[4] 42 U.S.C. §11111(a)(1)(d).

[5] WYO. STAT. ANN. § 35-17-101 (2008) *et seq.*

[6] WYO. STAT. ANN. § 35-17-102 (2008).

immunity for civil damages against a member of a peer review organization as a result of acts or omissions in performing peer review activities, except for intentional, malicious or grossly negligent acts or omissions resulting in harm.[7] The Wyoming act immunizes witnesses who provide information to the professional standard review organization,[8] and provides that all reports, findings, proceedings, and dates of the professional standard review organization are confidential and privileged, and that no person shall be compelled to testify as to what occurred in the professional standard review organization meetings.[9] Interestingly, Wyoming also has a separate quality management function statute which provides the same protections to hospitals licensed by the State of Wyoming.[10] The statute requires each hospital to implement a quality management function, provides immunity from suit in any civil action for good faith participation, and provides information relating to the evaluation or improvement of the quality of health care services is confidential.[11]

While the framework for the peer review process is generally outlined by both federal and state law, the specific details of the process are left up to each of the individual hospitals. Consequently, it is left to the board of trustees and the medical staffs of each individual hospital to determine the process by which practitioners are admitted to medical staff membership, the credentialing process, the peer review process, and the discipline process. As a result, there is a great deal of technical work which must be done to get a hospital's house in order prior to proceeding with a disciplinary action. Areas which must be addressed prior to a hospital conducting a disruptive physician peer review proceeding are the application and admissions process to the medical staff, the disruptive physician policy, a Title VII policy, an ADA compliance policy, a disciplinary action policy, and a fair hearing process policy. Each policy should coexist seamlessly with the other policies, and provide a comprehensive scheme for enforcement of disciplinary actions. Rest assured the practitioner who is the subject of any disruptive physician action will cry "foul" at the slightest hint of an internal or unwritten, policy deviation or legal violation. Those cries of "foul" will provide defense opportunities that are frequently "red herrings" but nevertheless detract from the central issue in front of the hearing panel—the behavior of the disruptive practitioner.

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[7] WYO. STAT. ANN. § 35-17-103 (2008).

[8] WYO. STAT. ANN. § 35-17-104 (2008).

[9] WYO. STAT. ANN. § 35-17-105 (2008).

[10] WYO. STAT. ANN. § 35-2-910 (2008).

[11] WYO. STAT. ANN. § 35-2-910 (2008).

III. DUE PROCESS REQUIREMENTS

An understanding of the Wyoming's due process requirements, HCQIA and case law is important to understand the preparation of policies for your hospital. The Health Care Quality Improvement Act requires certain due process protection, which has been supplemented by the courts.[12] Due process protections include:

1. The physician receives notice of a proposed action stating:

    a. a professional review action has been proposed;
    b. the reason[s] for the proposed action;
    c. a specification of the cases in which the practitioners professional performance was challenged and stating in reasonable fullness the nature of the criticism in each case;
    d. the physician's right to request a hearing on the proposed action;
    e. any time limit (of not less than 30 days) within which to request such a hearing; and
    f. a summary of rights in the hearing under paragraph 3.

2. If the physician requests a hearing, the physician must receive a notice of a hearing that states:

    a. The place, time and dates of the hearing, which date shall not be less than 30 days after the date of the notice of hearing; and
    b. a list of witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

3. Discovery of relevant records, including:

    a. access to all relevant hospital and medical records during the period provided for preparation and response.

4. If a hearing is requested on a timely basis, the hearing is to be held:

    a. before an arbitrator mutually acceptable to the physician and the health care entity;
    b. before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved; or

[12] 42 U.S.C. §11112 (1986).

c. before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved.

5. At the hearing, the physician has the right to:

a. representation by an attorney or other person of the physician's choice;
b. have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charge associated with the preparation thereof;
c. to call, examine and cross-examine witnesses;
d. to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and
e. to submit a written statement at the close of the hearing.

6. Upon completion of the hearing, the physician involved has the right to:

a. receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations; and
b. receive a written decision of the health care entity, including a statement for the basis of the decision.[13]

In addition to the procedures set forth in the Health Care Quality Improvement Act, the Wyoming Administrative Procedure Act (WAPA) sets forth another required series of due process protections hospitals must follow in administering contested case hearings.

WAPA requires notice to the affected Practitioner which sets forth:

1. The time, place and nature of the hearing;

2. The legal authority and jurisdiction under which the hearing is held;

3. The particular sections of the statutes and rules involved; and

4. A short and plain statement of the matters asserted.[14]

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[13] 42 U.S.C. §11112 (1986); Suckle v. Madison General Hospital, 362 F. Supp. 1196 (W.D. Wis. 1973).

[14] WYO. STAT. ANN. § 16-3-107(b) (2008).

Additionally, WAPA provides for the taking of depositions and discovery;[15] issuance of subpoenas;[16] the right to counsel;[17] the right to respond and present evidence and argument on all issues;[18] the requirement of keeping a record of the proceeding and what must be included in the record;[19] and the requirement for findings of fact.[20]

In addition to the prehearing procedural process, WAPA sets forth what evidence may be admitted, the need for cross examination, the type of documentary evidence to be produced, and the availability of the doctrine of judicial notice.[21] The statutes provide that the findings of fact and conclusions of law shall be set forth and separately stated in the final order, and the order shall be mailed to each party.[22] Hearing officers are given powers to administer oaths, issue subpoenas, rule upon evidence, regulate the hearing, determine procedural matters and recommend decisions, among other things.[23] It is important to note that hearing officers are prohibited from making final decisions.[24]

Drafting the policies in advance of the hearing is a complicated process, and should be undertaken or at least reviewed by experienced counsel for the healthcare entity who has special skills and experience in this area of the law. Careful preparation of the policies and bylaws of the hospital will insure the disciplinary action proceeding against a disruptive practitioner will stay as free of distractions as possible.

IV. APPLICATION FOR APPOINTMENT FOR MEDICAL STAFF

One document often overlooked in preparation of a hospital's internal documents is the Application for Appointment to Membership of the Medical Staff. An application for membership to the medical staff sets forth the terms and conditions of the relationship the hospital will have with the practitioner. The document, if carefully drafted, will contain: (1) a certification by the applicant that the application for medical staff membership is true and complete;[25]

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[15] WYO. STAT. ANN. § 16-3-107(g) (2008).

[16] WYO. STAT. ANN. § 16-3-107(d) (2008).

[17] WYO. STAT. ANN. § 16-3-107(j) (2008).

[18] WYO. STAT. ANN. § 16-3-107(j) (2008).

[19] WYO. STAT. ANN. § 16-3-107(o) & (p) (2008).

[20] WYO. STAT. ANN. § 16-3-107(r) (2008).

[21] WYO. STAT. ANN. § 16-3-108 (2008).

[22] WYO. STAT. ANN. § 16-3-110 (2008).

[23] WYO. STAT. ANN. § 16-3-112(b) (2008).

[24] WYO. STAT. ANN. § 16-3-112(e) (2008).

[25] Oftentimes, the practitioner will omit prior disciplinary incidents which later discovery will disclose. The certification of truthfulness and completeness will, in and of itself, give grounds for disciplinary action.

(2) a thorough checklist of the practitioner's history; (3) a statement the practitioner agrees to abide by the bylaws as now existing or hereafter amended;[26] and (4) will provide a release of liability for peer review and credentialing activities.

V. DISRUPTIVE PHYSICIAN POLICY

The next document which should be in place prior to bringing any proceeding against a disruptive practitioner is a disruptive practitioner policy. The American Medical Association (AMA) recommends each medical staff should adopt a policy which addresses personal conduct, whether verbal or physical, that affects or potentially may affect patient care as disruptive behavior.[27] The AMA recommends the policy should clearly state the principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment; describes the behavior that prompts intervention; provides a reporting channel; establishes a process to review or verify reports of disruptive behavior; establishes a process to notify the physician of the disruptive behavior report; includes a process for monitoring behavior improvement of the physician; provides for evaluative and corrective actions that are commensurate with the behavior; identifies the individuals involved; provides clear guidelines of confidentiality; and ensures individuals who report disruptive conduct are duly protected.[28]

Caution should be taken to ensure all organizational polices are consistent, and work to achieve the same ends. The policies should be seamless rather than separate and independent processes for notice and hearing. As will be discussed *infra*, the interaction of the disruptive conduct policy, the ADA policy, and the fair hearing policy need to be examined for inconsistencies, and also to insure a proper response is made to the behavior.

VI. IMPAIRED PRACTITIONER POLICY

It is estimated six percent (6%) of physicians have drug-use disorders and fourteen percent (14%) have alcohol-use disorders.[29] The next policy which should be prepared in advance of any disruptive practitioner matter is the impaired practitioner policy. In many cases, impairment causes the disruptive behavior. In many instances, a hospital will have made a substantial investment in practitioners admitted to their medical staff. Salvaging a career, and a relationship, by addressing

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[26] The "hereafter amended" language is important, because sometimes a practitioner will try to hold the hospital to the bylaws that were in existence at the time the practitioner applied for membership to the medical staff.

[27] AMA Policy H-140.918 Disruptive Physicians.

[28] *Id.*

[29] Stephen Ross, *Identifying the Impaired Physician,* Virtual Mentor, Ethics Journal of the AMA at 1, Dec. 2003.

underlying chemical or alcohol problems is an appropriate response, from a policy and community perspective. Additionally, the Joint Commission Manual requires the hospital to have a process for addressing impaired practitioners.[30]

The impaired practitioner policy should define the types of impairment applicable to the policy, provide a confidential treatment referral process, and provide for monitoring of the practitioner after treatment. The process should also include referral to the disciplinary action process if the practitioner fails to address the impairment issues through the impaired practitioner policy. Care must be taken to insure the seamless interaction of the impaired practitioner policy with the disciplinary action policy, so that the information and notices provided under one policy are interoperable with the other policy. Otherwise, practitioners subject to the impairment will likely object that one process or the other was not followed correctly, placing the status of procedural due process in jeopardy.

Wyoming has created the Wyoming Professional Assistance Program (WyPAP). The WyPAP program has been very successful in monitoring impaired practitioners. Upon completion of treatment, the impaired practitioner signs an agreement which includes a provision for chemical monitoring and testing, and a voluntary agreement that if the practitioner fails a chemical test, the practitioner will resign their Wyoming medical license.[31] As a result, WyPAP has a very high success rate in treating impaired practitioners within the State of Wyoming.

VII. AMERICANS WITH DISABILITIES ACT

Two provisions of the Americans with Disabilities Act have possible application to disruptive physicians. Title 1 of the ADA applies to employment relationships—and thus the employed physician relationship. The act requires employers to make reasonable accommodations for employees who have a physical or mental impairment which limits one or more major life activities.[32] To be a qualified individual with a disability, the individual must be able to perform, with or without reasonable accommodation, the essential functions of the job in question.[33] Employers are required to reasonably accommodate known disabilities of an individual under the ADA unless the accommodation would cause undue hardship.[34]

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[30] JCAHO Standard MS 4.80.

[31] Wyoming Professional Assistance Program, Monitoring Agreement, http://www.wpapro.org/Agreement.htm (last visited March 30, 2008).

[32] 42 U.S.C. § 12112(a) (1990).

[33] 42 U.S.C. § 12111(8) (1990).

[34] 42 U.S.C. § 12111(9) (1990).

Title III of the ADA prohibits discrimination based on a disability in a public accommodation and services operated by private entities.[35] The ADA includes hospitals as a place of public accommodation.[36] A case interpreting Title III of the ADA, ruled the accommodations required under Title III apply to physicians on the medical staff.[37] As a result, both employed physicians and medical staff members are parties covered by the reasonable accommodation provisions of the ADA.[38]

Whether a disability is covered by the Act is a technical question, and should be answered on a case-by-case basis. Active substance abuse is not covered.[39] However, "rehabilitated" individuals are protected by the ADA.[40] For those engaged in direct patient care in a hospital, the person with the disability has a higher burden to demonstrate the disability will not negatively impact patient care.[41] Other cases have addressed the same issue. When an employee relapsed after his treatment for drug and alcohol abuse and was terminated, the court upheld the termination holding that no longer engaging in drug use means being "in recovery long enough to have become stable."[42] In *Colorado State Board of Medical Examiners v. Davis,*[43] the court held that evidence of current use of illegal drugs does not shield the physician from losing his license.[44]

When contemplating a disruptive physician action, the hospital should assess the possibility of a disability, whether in the context of recovery for substance abuse, or mental illness or physical malady which manifests itself as behavioral problems (e.g. diabetes). If a disability exists, a reasonable accommodation should be considered. If no reasonable accommodations are possible, then proceed with the disruptive physician action.

VIII. PROMULGATE YOUR RULES ACCORDING TO LAW

One common mistake made by hospitals throughout Wyoming is the failure to promulgate the rules according to the Wyoming Administrative Procedure Act. Wyoming Statute § 16-3-102 provides that no agency rule, order or decision is valid or effective against any person or party, nor may it be invoked by the agency

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[35] 42 U.S.C. § 12182 (1990).

[36] 42 U.S.C § 12181(7)(F) (1990).

[37] Menkowitz v. Pottstown Mem'l Med. Ctr., 154 F.3d 113, 122-23 (3rd Cir. 1998).

[38] *Id.*

[39] 42 U.S.C. § 12114(b) (1990).

[40] 42 U.S.C. § 12114(b)(1) (1990).

[41] Altman v. New York City Health & Hosp. Corp., 100 F.3d 1054 (2nd Cir. 1996).

[42] McDaniel v. Miss. Baptist Med. Ctr., 877 F. Supp 321, 327-28 (S.D. Miss. 1995).

[43] Colo. State Bd. of Med. Exam's v. Davis, 893 P.2d 1365, 1368 (Colo. Ct. App. 1995).

[44] *Id.*

for any purpose until it has been filed with the registrar of rules (the County Clerk in this instance) and made available for public inspection as required by the Act. Failure to comply with this section may have the effect of voiding the rules adopted by your hospital. It has been argued in the past, the acceptance of the bylaws on the medical staff application makes the rules a contract, and thus, the rules are still effective. However, filing the rules with the County Clerk is a quick and easy step to insure the rules are effective, and avoids a defense which may be raised by the affected practitioner.[45]

IX. BE PREPARED FOR THE LONG HAUL

Disruptive physician actions may have serious consequences to the physician who is the subject of the action. Affected practitioners can be obstinate and lacking in pleasant interpersonal skills. Such factors, coupled with the fact the practitioners are financially able to afford protracted litigation, means anyone embarking on a disruptive practitioner action should plan to be in litigation for the long haul. While disruptive practitioner proceedings are sometimes easily resolved, our suggestion is to plan on being in the matter for the distance, and adopt litigation strategies which reflect the commitment of your hospital to the proceedings. As a practical matter, the hospital should conduct a thorough investigation of the allegations. The investigation should be conducted by outside legal counsel, or an independent investigator hired by outside legal counsel. Witness statements should be prepared, and if possible, signed by the witnesses. Memories change over time, and a contemporaneous statement of the facts is invaluable in preserving the facts. Preparing for a lengthy process allows the hospital to gather the necessary witness information anticipate defenses, and close loopholes early in the process. This preparation usually results in a quicker and less expensive resolution, than in instances where the matter inefficiently proceeds with little attention to detail or documentation, and then slowly snowballs into major litigation. By preparing early, and isolating the relevant facts, the focus of the matter can be limited to the behavior in question. The way the matter proceeds from inception is within in the control of the hospital and the medical staff. The strategy of the hospital and of the medical staff should be established at the beginning, and then followed throughout the stages of the action.

Often, medical staffs proceed without the involvement of legal counsel. Many times, practitioners view legal counsel as antagonistic, especially the hospital's legal counsel. Often, the medical staff's mind set is to quickly assess the problem, prescribe a course of action, and solve the problem. The process is in many ways

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[45] *See* Smith v. Deaconess Hosp., 161 P.3d 314 (Okl. 2007) (holding bylaws are a contract), Richter v. Danbury Hosp., 759 A.2d 106 (Conn. 2003), (holding bylaws are a contract); *but see* Vesom v. Atchison Hosp. Ass'n, No. 04-2218, 2006 WL 2714265 (D. Kan. 2006) (holding bylaws are not a contract).

counter-intuitive to the scientific knowledge base of the practitioner. Disruptive physician proceedings often fall outside the physician's set of concrete experiences. Fuzzy testimony, stories that do not match, distorted perceptions, outright lying and deeply rooted personality issues do not lend themselves easily to the physician mind set paradigm. The temptation is to resolve the matter informally with a collegial chat. Sometimes those chats work. Many times, they do not. As a result, the hospital and the medical staff should engage legal counsel, at the beginning, to document the case, and prepare for litigation. In other words, the hospital should follow the rules. The medical staff is frequently sensitive to the perception the hospital administration or the hospital board is trying to usurp the physician's authority to regulate his or her own medical staff. One way to diffuse this perception is to suggest that counsel separate from the hospital's general counsel be retained to represent the hospital in the proceedings. However, remember the client is the hospital not the medical staff.

X. FOLLOW THE RULES

By now, the hospital has prepared its policies. It has engaged counsel and done a thorough investigation of the matter. Witness statements have been gathered, a strategy determined, and the hospital and medical staff are prepared to proceed with the disruptive physician disciplinary action. Carefully following the rules, as set forth in the hospital and medical staff bylaws and policies, HCQIA and Wyoming Statutes will allow the action to proceed without distraction. Varying from the rules in any way, will give the affected practitioner grounds to complain, or in the worst case scenario, grounds on which to sue the hospital. Think of procedural due process as a cook book recipe. Follow the instructions, step by step, one step at a time. If you do not, the end product will be distasteful.

The medical staff should document, early on, its grounds for taking the action. "Document" in this instance is defined as a thorough, comprehensive, written report that describes and evidences the process every step of the way. Items to be documented include:

1. Why the medical staff has a reasonable belief the action is in furtherance of quality health care.

2. The steps it took to gather the facts of the matter.

3. The methodology utilized by the medical staff to follow the bylaws and procedures and to provide a fair hearing to the affected practitioner.

4. The facts which lead to a reasonable belief the action is warranted under the circumstances.

Care should be taken in documenting these facts, because this documentation will serve as the basis for immunity from suit under Wyoming Law, and immunity from damages under HCQIA. The documentation serves two purposes. First, it forces the medical staff to clearly articulate its grounds for proceeding with the action. And second, it provides documentation later on of the rationale for proceeding.

Somewhere in the process, allegations will likely be made by the affected practitioner regarding improper motives, revenge, and the infamous "green eyed monster" which gave rise to the peer review action. The proper documentation of the reasons and the facts underlying the reasons are the best tool for combating the inevitable red herrings which will arise later in the process. In addition to complying with the rules and requirements contained in HCQIA, the hospital must also comply with the Wyoming Statutes governing contested cases contained in the Wyoming Administrative Procedure Act. First and foremost in those statutes is the requirement of an unbiased hearing panel. Wyoming Statute § 16-3-111 provides:

> Unless required for the disposition of ex parte matters authorized by law, members of the agency, employees presiding at a hearing in a contested case and employees assisting the foregoing persons in compiling, evaluating and analyzing the record in a contested case or in writing a decision in a contested case shall not directly or indirectly in connection with any issue in the case consult with any person other than an agency member, officer, contract consultant or employee or other state or federal employee, any party other than the agency or with any agency employee, contract consultant or other state or federal employee who was engaged in the investigation, preparation, presentation or prosecution of the case except upon notice and opportunity for all parties to participate. Nothing herein contained precludes any agency member from consulting with other members of the agency. No officer, employee, contract consultant, federal employee or agent who has participated in the investigation, preparation, presentation or prosecution of a contested case shall be in that or a factually related case participate or advise in the decision, recommended decision or agency review of the decision, or be consulted in connection therewith except as witness or counsel in public proceedings. A staff member is not disqualified from participating or advising in the decision, recommended decision or agency review because he has participated in the presentation of the case in the event the staff member does not assert or have an adversary position.[46]

[46] WYO. STAT. ANN. § 16-3-111 (2008).

Essentially, those persons who must make the ultimate decision in an administrative hearing cannot participate in the preparation, presentation or prosecution of the case. Consequently, the hospital's governing body may be informed generally about the existence of the matter and may make such necessary decisions like deciding to finance the matter, but should be insulated from the underlying facts of the case. Wyoming case law provides for *voir dire* of the panel for bias, and such insulation of the governing body allows it to be the ultimate decision maker, based upon the report of the arbitrator, hearing officer or hearing panel.[47] The process of the hearing should be governed by the rules we discussed earlier in this document. Insure the rules and statutory provisions are followed.

The Wyoming Supreme Court has set forth additional requirements regarding professional licensing hearings. In *Devous v. Board of Medical Examiners*, the Wyoming Supreme Court held that before a physician can lose his license to practice medicine, there must be adequate notice of the violations, and the licensing board's burden of proof is that of clear and convincing evidence.[48] In *Painter v. Abels,*[49] the Wyoming Supreme Court had the opportunity to extend the rules set forth in the *Devous* case. In *Painter*, the Wyoming Supreme Court held the physician must receive clear notice of the charges pending, be provided with adequate discovery, have a fair hearing panel, expert testimony supporting the positions of the Board of Medicine, and reiterated the burden of proof of clear and convincing evidence.[50] In *Dorr v. Board of Certified Public Accountants*[51] the Wyoming Supreme Court set forth the standards of appellate review in licensing hearings.[52] In that case, the courts would defer to the administrative agency's wisdom unless the decision was clearly erroneous, against the substantial weight of the evidence or an abuse of discretion.[53]

One final note about the hearing process: the proceedings are confidential. Failure to maintain that confidentiality gives rise to a cause of action for defamation or wrongful disclosure of confidential medical information. A hospital can carefully negotiate all of the requirements of due process, gain an order of discipline with the practitioner, and then compromise it all by failure to maintain confidentiality. Furthermore, failure to maintain confidentiality is an easy civil case to prove against the hospital.

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[47] Board of Trustees, Laramie Co. School District No. 1 v. Spiegel, 549 P.2d 1161, 1165 (Wyo. 1976).

[48] Devous v. Bd. of Med. Exam'rs, 845 P.2d 408, 415-16 (Wyo. 1999).

[49] Painter v. Abels, 998 P.2d 931 (Wyo. 2000). It is interesting to note that during the times these violations allegedly occurred, Dr. Devous was married to Dr. Painter.

[50] *Id.* at 937-39, 941.

[51] Dorr v. Bd. of Certified Pub. Accountants, 146 P.3d 943 (Wyo. 2006).

[52] *Id.* at 948-49.

[53] Id. at 949; *See also* Medcalf v. Coleman, 71 P.3d 53 (Okla. Civ. App. 2003) (holding the court would not substitute its judgment for the judgment of the hospital board).

XI. ANTICIPATE THE DEFENSES

Disruptive physician contested case matters follow a remarkably similar pattern. Not unlike the domestic abuse cycle, the pattern in disruptive physician matters is often recurrent. Anticipating and planning for the affected practitioner's responses are essential to successfully prosecuting disruptive practitioner proceedings. Nothing short of absolute commitment to the sanctity of the process, without pre-judgment, is essential. The practitioner's first response is often, this would not have happened except for the incompetence of those around me. The disruptive practitioner, in responding to the action, may attempt to turn himself into a whistle blower, and claim the action was in retaliation for the practitioner's whistle blowing activities. Wyoming has a whistle blower protection statute which applies specifically to those involved in health care which provides:

> Health care facilities subject to or licensed pursuant to this act shall not harass, threaten discipline or in any manner discriminate against any resident, patient or employee of any health care facility for reporting to the division a violation of any state or federal law or rule and regulation. Any employee found to have knowingly made a false report to the division shall be subject to disciplinary action by the employing health care facility, including but not limited to, dismissal.[54]

Care must be taken to insure the action against the affected practitioner is not taken in retaliation for whistle blowing activities. A strategy which may be used to address the whistle blower concerns are to separate those who were the subject of the original reporting, if any, from the disruptive physician action. Every effort should be made to maintain a fair, balanced and independent hearing panel.

Another response of the practitioner may be to allege improper motive. He or she may allege the action is motivated by political, economic, personality conflicts, incompetent accusers, or timing to interfere with business opportunities. Prior to bringing the action, the hospital should look for any underlying hidden motives of any of the accusers or victims. Those persons participating in the process, other than witnesses, who have some tangible interest which could possibly be distorted into an improper motive for the proceeding should be asked to excuse themselves from the process, if possible. Such preventative action is another anticipatory action which should be taken to keep the focus on the conduct of the affected practitioner.

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[54] WYO. STAT. ANN. § 35-2-910(b) (2008).

XII. GETTING SUED

The disruptive practitioner is in the proceedings because he or she cannot play well in the sandbox with others. If a disruptive practitioner action is brought, the hospital should plan on being counter-sued, both as a harassment tactic and as revenge. The lawsuits do not always happen; but they occur, or are threatened with such regularity that it should come as no surprise when the lawsuit comes. If you follow no other advice from this article, follow this point. Prior to undertaking a disruptive practitioner action, make sure your organization has directors and officers insurance which covers every person who participates in the process. The insurance will provide a defense, at minimum, and likely cover any claims if the action against the hospital is successful.

The most remarkable of the reported cases in this area of the law is *Poliner v. Texas Health Systems*,[55] in which a cardiologist was awarded a $366 million dollar verdict arising from the suspension of his cardiac cath lab privileges.[56] The case is a model of what not to do in peer review actions. The peer review committee did not document the evidence necessary for a suspension.[57] They proceeded with an emergency suspension without granting a hearing.[58] Later, one of the doctors testified he did not have enough information to assess whether Dr. Poliner posed a present danger to his patients.[59] Three out of four of the patients which formed the basis for the emergency suspension were treated months earlier, and thus those cases could not have posed an immediate danger.[60] The committee did not consider less severe options.[61] The committee was comprised of economic competitors of Dr. Poliner.[62] Dr. Poliner was told he could not consult an attorney prior to the committee taking action.[63] And finally, Dr. Poliner was not given an opportunity to offer any explanation in any of the cases.[64] Commentators have referred to this type of peer review as "sham" peer review, conducted for motives other than the quality of care, and thus the $366 million dollar verdict was justified.[65]

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[55] Poliner v. Texas Health Sys., No. Civ. A. 3:00-CV-1007-P, 2003 WL 22255677, at 3 (N.D. Tex. Sept. 30, 2003); *See also* Poliner v. Texas Health Sys., No. Civ. A. 3:00-CV-1007-P, Verdict & Settlement Summ., 2004 WL 2563600 (N.D. Tex. Aug. 27, 2004).

[56] *Poliner*, No. Civ. A. 3:00-CV-1077-P, at 3.

[57] *Id.* at 3.

[58] *Id.* at 3.

[59] *Id.* at 13.

[60] *Poliner*, No. Civ. A. 3:00-CV-1077-P, at 3.

[61] *Id.* at 3.

[62] *Id.* at 3.

[63] *Id.* at 3.

[64] *Id.* at 3.

[65] *Poliner*, No. Civ. A. 3:00-CV-1077-P, at 3.

However, for every *Poliner* case, there are cases which end up summarily dismissed.[66] The bottom line is an action is likely to bring a reaction. If the hospital has followed the procedural steps, and conducted the disruptive physician action in good faith, most likely the lawsuit will be dismissed, and HCQIA and state law immunities will be enforced. If the action is motivated by improper or ulterior motives the likelihood of exposure for damages is greatly enhanced.

XIII. STRATEGIES FOR SUCCESS

The following strategies for success are offered as a result of our experiences in dealing with disruptive physicians. The list is not all inclusive, but will give some guidelines to avoid common pitfalls.

1. "Due diligence" is not just a catch phrase. Do the hard work in advance or as the wise, greasy mechanic once opined, "You can pay me now, or you can pay me later."

2. Put your house in order. Make sure your policies comply with both state and federal laws. Record your policies with the county clerk.

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[66] *See* for example Vranos v. Franklin Med. Ctr., 862 N.E.2d 11 (Mass. 2007), (A suit for defamation was dismissed because a peer review committee shared its disruptive doctor findings that Dr. Vranos used intimidating, abusive and hostile behavior, and exhibited threatening behavior toward another physician with the Board of Medicine.); Curtsinger v. HCA, 2007 WL 124294 (Tenn. Ct. App. 2007) (A suit for breach of contract, interference with prospective economic advantages, interference with right to practice medicine, civil conspiracy, antitrust, conspiracy to restrain trade, wrongful reporting of confidential information, bad faith and libel were all dismissed for failure of the physician to prove a violation of HCQIA standards.); Bryan v. James E. Holmes Regl. Med. Ctr., 333 F.3d 1318 (11th Cir. 1994) (holding that 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 regularly viewed it as his obligation to criticize staff members at [the Hospital] for perceived incompetence or inefficiency, some of which occurred in front of patients about to undergo surgery); Morgan v. PeaceHealth, Inc., 14 P.3d 773 (Wash. Ct. App. 2000) (upholding immunity when the physician's privileges were suspended for sexual harassment and inappropriate behavior with patients); 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); Joseph v. Univ. of Texas, 2005 WL 3591018 (S.D. Tex. 2005) (holding the disciplinary action was not based on the physician's race); Catipay v. Humility of Mary Health Partners, 2006 WL 847235 (Ohio App. 2006). A physician was suspended for disruptive behavior for posting the Kama Sutra Indian Sex Guide on the hospital bulletin board; and posted an article titled "Police say man kills wife at work" in the labor and delivery unit with his hand written comments stating "This happens when wives talk too much. They never learn, they never stop, Why?"; and for sending naked pictures of men's buttocks to the nurse's station with his name or the name of an actor written on each man's buttocks; and posting an article entitled "Cohabitation, Contraception and Sperm Exposure" on a bulletin board with a bulleted item referring to oral sex, discussing with nurses why men enjoy performing oral sex on woman and other specific sexual references, was not terminated in violation of HCQIA standards. *Id.*

3. Document informal disciplinary conversations. Seemingly insignificant discussions now, may later become critical evidence.

4. Triage your actions. Know you are going to be in the matter for the long haul. After you make the decision and decide to go forward, stick to your guns.

5. Deal with the physician where they live. Take a scientific approach. Identify the behaviors that are unacceptable and communicate them to the physician. Disruptive professionals rarely seek independent help. Following aggressive intervention and assessment, the majority develop at least positive insight.[67] Prior to confrontation, determine in advance acceptable outcomes. Consider what treatment or therapy is available in lieu of assessment. Send the message that disruptive conduct will not be tolerated and follow through on that message.

6. Prepare your case in detail, early on. Make sure to document witness interviews. Take statements and prepare to go the distance. Engage the services of experts, early. Use their insight to guide you in the case.

7. Involve legal counsel early. Early involvement of experienced legal counsel can assist in avoiding the legal pitfalls. Additionally, the interviews and facts gathered in preparation for the action may be protected as both work product and privileged communications.

8. Thoroughly prepare your case prior to filing the action. Make sure your evidence is documented. Be able to clearly articulate the behaviors which are inappropriate and the actions the hospital chooses to take. Avoid changing your position on the issues mid-stream.

9. Once you have developed your case, disclose the complaints, the evidence and the proposed course of action to the affected practitioner. Don't hide anything. Hiding evidence, even evidence counter to your case, may constitute a denial of due process.

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[67] Irons M.D., R, *The Behaviorally Disruptive Physician*, http://prckansas.org/articles/Behaviorally_Disruptive_Physician.htm (last visited March 28, 2008).

10. Hire a hearing officer who is experienced and well versed with health care law. An adept hearing officer can be a line of defense for the healthcare entity in insuring due process rights are protected and avoiding a later law suit for denial of due process under 42 U.S.C. §1983.[68]

11. Don't be intimidated, and protect your employees from intimidation. Don't let the practitioner bully your staff and other physicians into submission on the disruptive behavior action. Anticipate such intimidation will occur, and take measures to protect your people from intimidation. If the intimidation occurs, document it, and report it to the hearing officer, and ask for a protective order against the affected practitioner.

12. Don't tolerate disruptive behavior. A lack of institutional response can compromise staff morale, retention and affect patient care.[69]

13. Encourage the practitioner to submit to an assessment. Use a sophisticated forensic psychiatrist experienced in disruptive physician behavior. Don't let the practitioner be the sole source of information to the assessing psychiatrist. If the practitioner is the sole source of information, the assessing psychiatrist will not have the opportunity to see the full facts. Provide the assessing psychiatrist with a statement of the charges and evidence against the affected physician. Give the forensic psychiatrist the information needed to make a full and fair diagnosis.

14. Keep a firm hand in the administrative process, but work toward an amicable solution. Determine a solution. The best way to obtain a negotiated solution is to work from a position of strength in the administrative proceeding. Plan to go the distance, and prepare for going the distance, but keep options open with a problem solving result in mind.

15. If an agreed solution cannot be reached, don't cut corners. Prepare the case thoroughly. Try the case. Allow the process to work.

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[68] *See* 42 U.S.C.A. § 1983 (2008).

[69] D. Meyer and M. Price, *Forensic Psychiatric Assessments of Behaviorally Disruptive Physicians,* Journal of American Academy of Psychiatry and the Law, 34:72–81, 2006.

16. Follow the rules. Don't give the affected practitioner technicalities upon which to avoid consequences by making mistakes. Provide procedural due process. Provide substantive due process.

17. Insure your hearing panel and your governing body are unbiased.

18. Keep everyone's mouth shut. Medical staff proceedings are confidential. Don't give an affected practitioner a cause of action against the medical staff and the hospital for wrongful disclosure of confidential medical information. Don't give the affected practitioner a tool with which to continue to be disruptive to your day to day operations.

19. Don't allow the disruptive practitioner process to be used for hidden agendas. Focus only on disruptive practitioner behavior.

XIV. CONCLUSION

By the time the medical staff, or the administration, or the governing body finally begins to consider corrective action with a disruptive physician, the emotions have usually become inseparable from the process. Breathe. Place the responsibility in the hands of a professional who is trained to focus on the delicate balance between the competing interests of the health care entity, the practitioner, and the health care community. Remember, there is nothing less at risk, than the economic life of a professional, and the physical lives of people who need care.