



Medical Quality Assurance Commission

WORKSHOP PACKET

August 25-26, 2011

Department of Health
Medical Quality Assurance Commission
Point Plaza East
310 Israel Road SE
Tumwater, WA 98501
Phone: (360) 236-4700

“ Public Health—Always Working for a Safer and Healthier Washington
“

Medical Quality Assurance Commission (MQAC)

Educational Workshop Schedule

August 24-26, 2011

Using National Research and Data to Enhance MQAC's Approach to Patient Safety

Department of Health Offices
Point Plaza East (PPE)
310 Israel Road SE
Tumwater, Washington 98501

WEDNESDAY – August 24, 2011 – PPE, Rooms 131, 152 and 153				
	9:00 a.m.	Orientation	New Member Orientation	131
	10 a.m. to noon	Disciplinary Session	Case Reviews - Panel A	152
	10 a.m. to noon	Disciplinary Session	Case Reviews - Panel B	153
	Noon to 12:30 p.m.		Lunch	152/153
	12:30 p.m.	Disciplinary Session	Case Reviews – Panel A	152
	12:30 p.m.	Disciplinary Session	Case Reviews – Panel B	153
THURSDAY – August 25, 2011 – PPE, Rooms 152 and 153 -- OPEN SESSIONS				
1.	8:00 to 9:00 a.m.	Plenary Presentation	Welcoming Remarks: MQAC Chair, Mimi Pattison, MD Keynote Speaker: John Nance, J.D., author, safety expert, and founding board member of the National Patient Safety Foundation. Mr. Nance is the author of <i>“Why Hospitals Should FLY: The Ultimate Flight Plan to Patient Safety and Quality Care”</i> . The book received the James A. Hamilton 2009 Book of the Year Award from the American College of Healthcare Executives.	
	9:00 to 9:15 a.m.		Break	
2.	9:15 to 10:45 a.m.	Plenary Presentation	Improving the Response to Adverse Events: Washington State Agency for Healthcare Research and Quality (AHRQ) HealthPact Pilot of the Disclosure and Resolution Process Thomas H. Gallagher, MD, University of Washington; Atul Gawande, MD (by teleconference from Harvard); Michelle Mello, JD, PhD (by teleconference from Harvard); (panel participants: Physician’s Insurance, Washington State Hospital Association, Washington State Medical Association, plaintiff attorney, patient advocate)	
	10:45 to 11:00 a.m.		Break	
3.	11:00 to 11:45 a.m.	Plenary Presentation	Understanding and Managing Physicians with Disruptive Behavior Kent E. Neff, MD, FAPA. Founder and former CEO, Springbrook Institute, Inc.; expert witness, health care and industry consultant on influencing physician behavior.	



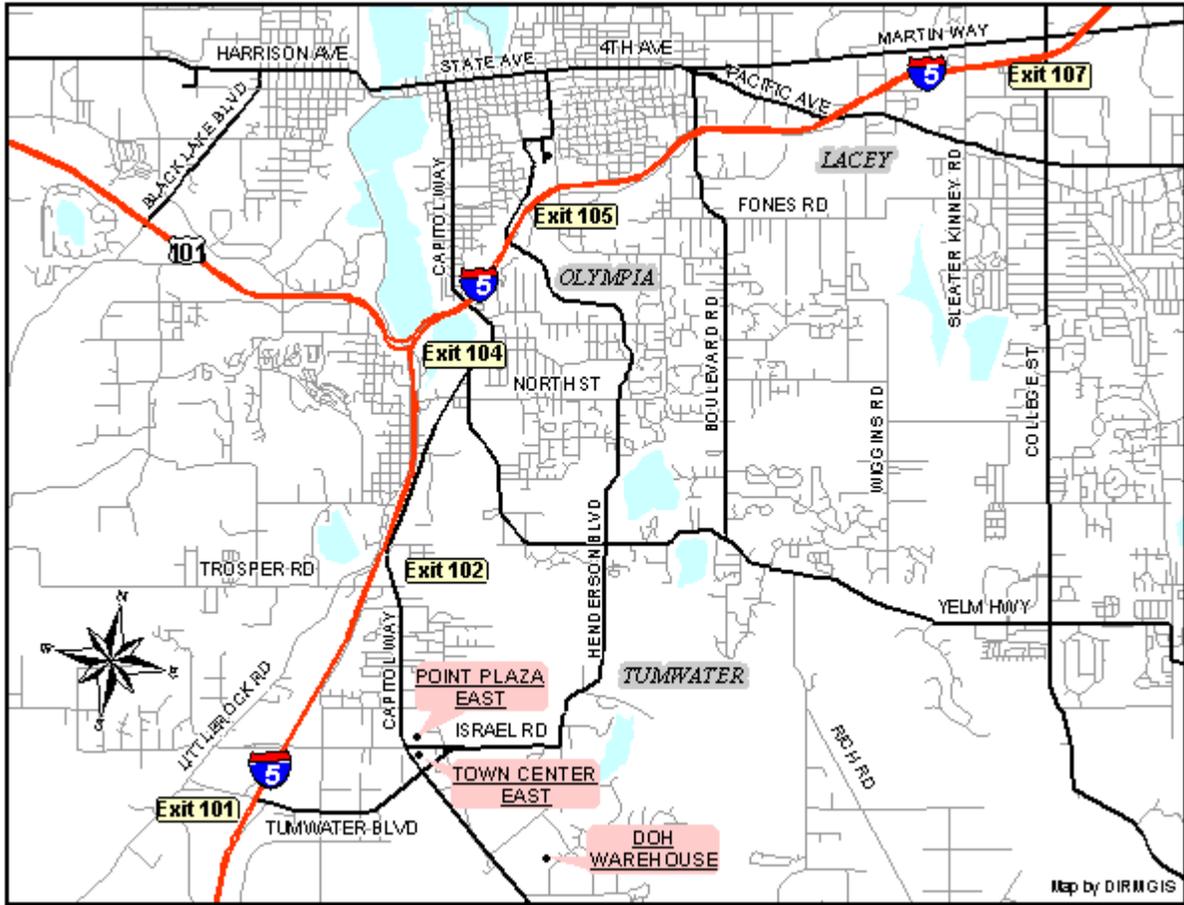
	11:45 a.m. to 1:00 p.m.	Lunch	Introductions of MQAC Members, Key Staff and Guests Maryella Jansen, Executive Director; Mimi Pattison, MD, Chair and Leslie Burger, MD, Immediate Past Chair
4.	1:00 to 2:30 p.m. and 3:00 to 4:30 p.m.	Breakout Sessions (repeated back to back)	A: Designing Effective Discipline for Disruptive Physicians (PPE Rooms 152/153) Presenter and Facilitator: Kent Neff, MD, FAPA. Founder and former CEO, Springbrook Institute, Inc.; expert witness, health care and industry consultant on influencing physician behavior. B: New York Chapter, American College of Physicians, New York State Near Miss Registry (Town Center One, Room 163) Presenter: Alwin Steinmann, MD, Chief of Academic Medicine/Exempla, Saint Joseph Hospital, Denver, Colorado Facilitator: Megan Davis, Washington State Department of Health
5.	4:30 – 5:00 p.m.	Plenary Discussion	Report Back from Break-out Sessions (PPE Rooms 152/153)

FRIDAY – August 26, 2011 – PPE, Rooms 152 and 153 -- OPEN SESSIONS

1.	8:00 to 9:00 a.m.	Plenary Presentation	MQAC Pilot Project Update Presenters: Michael Farrell, JD, Legal Unit Manager and Micah T. Matthews, Research and Education Manager
2.	9:00 – 9:15 a.m.		Break
3.	9:15 to 10:15 a.m.	Plenary Presentation	Keys to Transparency: The Importance of Consistency and Predictability in Disciplinary Proceedings. Presenter: Kim O'Neal, Supervising Assistant Attorney General
4.	10:15 – 10:30 a.m.		Break
5.	10:30 a.m. to noon	Plenary Session	Review of draft MQAC policy on Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery, MD2011-08 Facilitator: Michael Bahn, JD
6.	Noon to 12:30 p.m.		Lunch
	12:30 to 1:00 p.m.	Training	Commission Member Computer Training
	1:00 p.m.		Adjourn

NOTICE

This meeting is accessible to persons with disabilities. Special aids and services can be made available upon advance request. Advance request must be made no later than August 23, 2011. For information and assistance, call program staff directly at (360) 236-2757. TDD may also be accessed at 1-800-525-0127 (please wait to be transferred) or by calling (206) 664-0064. Smoking is prohibited at this meeting. Please note that a portion of this workshop will be video-taped.



ECONOMIC SHOWDOWN IN HEALTHCARE

WSBA-CLE

CO-SPONSORED BY THE WSBA HEALTH LAW SECTION

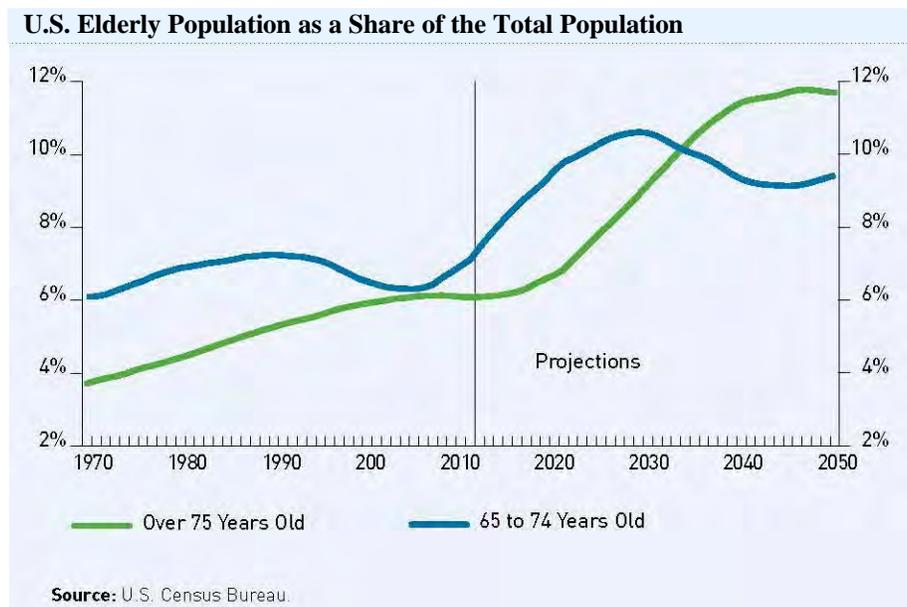
June 23, 2011

**Madeline Engel
Miller Nash LLP**

WHERE WE BEGIN – The Baby Boom Sets the Economic Showdown Into Motion

“Take the 3,548,000 babies born in 1950. Bundle them into a batch, bounce them all over the bountiful land that is America. What do you get? Boom. The biggest, boomiest boomy boom ever known in history.” - Sylvia Porter, *New York Post*, May 4, 1951.

With the end of World War II in 1945 came a surge of births in the United States, which reached a record level in 1957 with 4.3 million new births. The unprecedented number of people born from 1946 to 1964 are referred to as the baby boomer generation, and their steady progression toward the age of 65 is a driving force behind the changes in health care over the past 30 years.



In 2011, the oldest baby boomers turned 65, which qualified those individuals for government-funded Medicare. And, with 10,000 baby boomers turning 65 every day (a pattern that will continue for the next 19 years), the entire health care system is searching for ways to provide for the flood of new Medicare patients while delivering the best possible care. It appears that the solution may drastically alter the traditional private-practice model, as the economic showdown between payers and physicians drives physicians into employment with hospitals and drives hospitals into integrated networks.

Per Capita Health Care Costs by Age Groups

Age Group (Years)	Total	Total Private	Primary Health Insurance	Out of Pocket	Other Private	Total Public	Medicare	Medicaid	Other Public
Total	\$5,276	\$2,921	\$1,898	\$802	\$221	\$2,355	\$1,032	\$918	\$405
0-18	\$2,650	\$1,558	\$1,096	\$338	\$124	\$1,092	\$2	\$819	\$271
19-44	\$3,370	\$2,269	\$1,559	\$520	\$190	\$1,100	\$87	\$662	\$351
45-54	\$5,210	\$3,760	\$2,570	\$899	\$290	\$1,451	\$310	\$737	\$403
55-64	\$7,787	\$5,371	\$3,784	\$1,225	\$363	\$2,415	\$706	\$1,026	\$683
65-74	\$10,778	\$3,851	\$2,174	\$1,437	\$241	\$6,927	\$5,242	\$1,112	\$573
75-84	\$16,389	\$5,066	\$2,428	\$2,281	\$358	\$11,323	\$8,675	\$2,058	\$590
85+	\$25,691	\$8,304	\$2,817	\$4,886	\$601	\$17,387	\$10,993	\$5,424	\$970
0-18	\$2,650	\$1,558	\$1,096	\$338	\$124	\$1,092	\$2	\$819	\$271
19-64	\$4,511	\$3,117	\$2,154	\$722	\$241	\$1,395	\$239	\$738	\$417
65+	\$14,797	\$4,888	\$2,351	\$2,205	\$331	\$9,909	\$7,242	\$2,034	\$633

Source: Centers for Medicare and Medicaid Studies.

WHERE WE WERE: The Independent Medical Staff

In the mid-1980s, the trend among physicians was to build or join entrepreneurial private-practice groups, which created a cottage industry of independent practices. These private physicians then sought staff privileges at hospitals, where they delivered inpatient care of medical diseases, surgery, and childbirth. In essence, the physicians were the customers of the hospitals. Although Medicare paid lower reimbursements than private insurance, private practices could afford to accept the lower Medicare payments as a cost of doing business. Remember, at this time, baby boomers were at an average age of 21 to 39 years old, so Medicare reimbursements were not a significant source of revenue and could be offset by higher reimbursements from private insurance.

On the legal side, the separateness between the hospital and its independent medical staff led to many issues, mainly due to lack of oversight of physician performance and competence. Therefore, in 1984, the legal system focused on creating a body of law to govern the quality of care delivered by hospitals and physicians. The solution was to create a peer review system that monitored the performance of independent physicians, because other physicians were in the best position to observe, address, and prevent behavior that could lead to malpractice.

1. Washington Supreme Court Adopts the Theory of Corporate Negligence.

In *Pedroza v. Bryant*, 101 Wn.2d 226, 229-233, 677 P.2d 166 (1984), the Supreme Court of Washington adopted the theory of corporate negligence, which requires

hospitals to exercise reasonable care to ensure that the physicians selected to be member of the hospital's independent medical staff are competent. The court reasoned that the "doctrine of corporate negligence reflects the public's perception of the modern hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered." *Id.* at 231.

Furthermore, "[h]ospitals are also in a superior position to monitor and control physician performance." *Id.* As the court explained:

"Deviations from 'good' medical practice should be readily apparent at an early stage when preventive measures can be undertaken by the hospital to protect patients from possible injury. Early detection also enables the hospital to institute informal procedures which may adequately correct a problem before more formal sanctions are necessary." *Id.* at 232 (citation omitted).

The applicable standard of care under the theory of corporate negligence is defined mostly by the hospital's bylaws, because bylaws are statutorily "recommended" to follow Joint Commission standards and therefore are "based on national standards." *Id.* at 234. Thus, the court concluded, the "pertinent inquiry" under the corporate negligence theory is whether the hospital exercised the proper standard of care "in the granting, renewal, and delineation of staff privileges." *Id.* at 235.

Importantly, however, the court declined to extend the theory of corporate negligence to hold a hospital liable for the acts committed by an independent member of the medical staff in his or her private office where the plaintiff is not a patient of the hospital. *Id.* at 236-37. Therefore, the hospital's duty of care extends only to those who are patients within the hospital. *Id.* at 237.

2. Washington Legislature Reacts to *Pedroza*.

In 1985, the year after the Washington Supreme Court decided *Pedroza*, the Washington Legislature enacted RCW 70.41.200 to reduce medical malpractice by requiring hospitals to "establish coordinated medical malpractice prevention programs and provide greater scrutiny of physicians prior to granting or renewing hospital privileges." Laws of 1986, ch. 300, § 1. The statute requires every hospital to "maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice." RCW 70.41.200(1). The quality improvement programs must include eight components:

- (a) A "quality improvement committee" that reviews services rendered in the hospital and oversees quality improvement and medical malpractice prevention;
- (b) A medical staff privileges sanction procedure in which physicians' credentials, capacity, and competence are reviewed as part of an evaluation of staff privileges;
- (c) A periodic review of the credentials, capacity, and competence of all physicians employed by the hospital;

- (d) A prompt-resolution procedure for patient grievances;
- (e) Maintenance and collection of information about the hospital's negative health-care outcomes, patient grievances, costs from insurance and patient-injury prevention, and safety improvement activities;
- (f) Maintenance of relevant information about individual physicians that was gathered pursuant to the requirements of the quality improvement program;
- (g) Education programs about quality improvement, patient safety, medication errors, injury prevention, infection control, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients, and causes of malpractice claims for staff personnel engaged in patient-care activities; and
- (h) Policies to ensure compliance with the reporting requirements of this section.

RCW 70.41.200(1)(a)-(h).

The statute grants limited immunity from civil liability to any person who, in good faith, provides information to further the quality improvement program or participates on the quality improvement committee. RCW 70.41.200(2). The statute also creates a limited privilege for all information and documents created for, and collected and maintained by a quality improvement committee. RCW 70.41.200(3).

Importantly, to further encourage physicians to participate in the quality improvement or peer review programs, Washington has a statutory "peer review privilege" that protects these programs' written records, proceedings, and reports from discovery. RCW 4.24.250(1). The "peer review privilege" was enacted on the theory "that external access to committee investigations stifles candor and inhibits constructive criticism thought necessary to effective quality review." *Coburn v. Seda*, 101 Wn.2d 270, 275, 677 P.2d 173 (1984).

3. Federal Government Enacts the Health Care Quality Improvement Act.

In 1986, the federal government enacted the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. 11101-11152, in response to two concerns fundamental to hospitals consisting of independent medical staff: (1) prevention of the increasing number of incidents leading to medical malpractice, and (2) prevention of allowing incompetent physicians from moving to another state without disclosure of the physician's previous incompetent performance. *See* 42 U.S.C. 11101(1); *see also* Margot Heffernan, *The Health Care Quality Improvement Act of 1986 and the National Practitioner Data Bank: the controversy over practitioner privacy versus public access*, 84(2) BULL. MED. LIBR. ASSOC. 263, 263-69 (1996); *see also* 42 U.S.C. § 11101(2), (5).

To address the first concern, HCQIA establishes immunity from damage claims for participants in peer-review actions as long as the action was taken:

- (a) In the reasonable belief that the action was in the furtherance of quality health care,
- (b) After a reasonable effort to obtain the facts of the matter,
- (c) After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
- (d) In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. § 11111(a)(1), (2), 11112(a)(1)-(4). HCQIA does not, however, provide immunity from damage claims arising under any law relating to the civil rights of any person or persons, such as the Civil Rights Act.

To address the second concern, HCQIA requires hospitals to report to the National Practitioner Data Bank ("NPDB") any adverse action taken against a physician's staff privileges. 42 U.S.C. § 11133(1)(a). Specifically, HCQIA mandates that each health-care entity that accepts the surrender of a physician's clinical privileges while the entity is investigating the physician for possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding, to report the surrender of privileges. *See* 42 U.S.C. § 11133(a)(1)(B); 45 C.F.R. § 60.9(a)(1)(ii).

Information reported to the NPDB can be accessed by state licensing boards and any health-care entity where the physician is employed or affiliated or is seeking employment or affiliation. *See* 42 U.S.C. § 11137(a); 45 C.F.R. § 60.11. Hospitals are required to request information from the NPDB whenever a physician applies for a position on its medical staff or for clinical privileges, and also every two years to check the status of each physician who currently is on its medical staff or has clinical privileges. *See* 42 U.S.C. §§ 11135(a); 45 C.F.R. § 60.10. A person or entity reporting information as required by the HCQIA is immune from civil liability unless the information was known to be false. *See* 42 U.S.C. § 11137(c).

Notably, HCQIA allows states to grant additional protections under each state's own law to those engaged in a professional review action. 42 U.S.C. § 11115(a). As discussed below, Washington has granted such additional protections.

4. Washington Legislature Adopts HCQIA Through the Washington Peer Review Act.

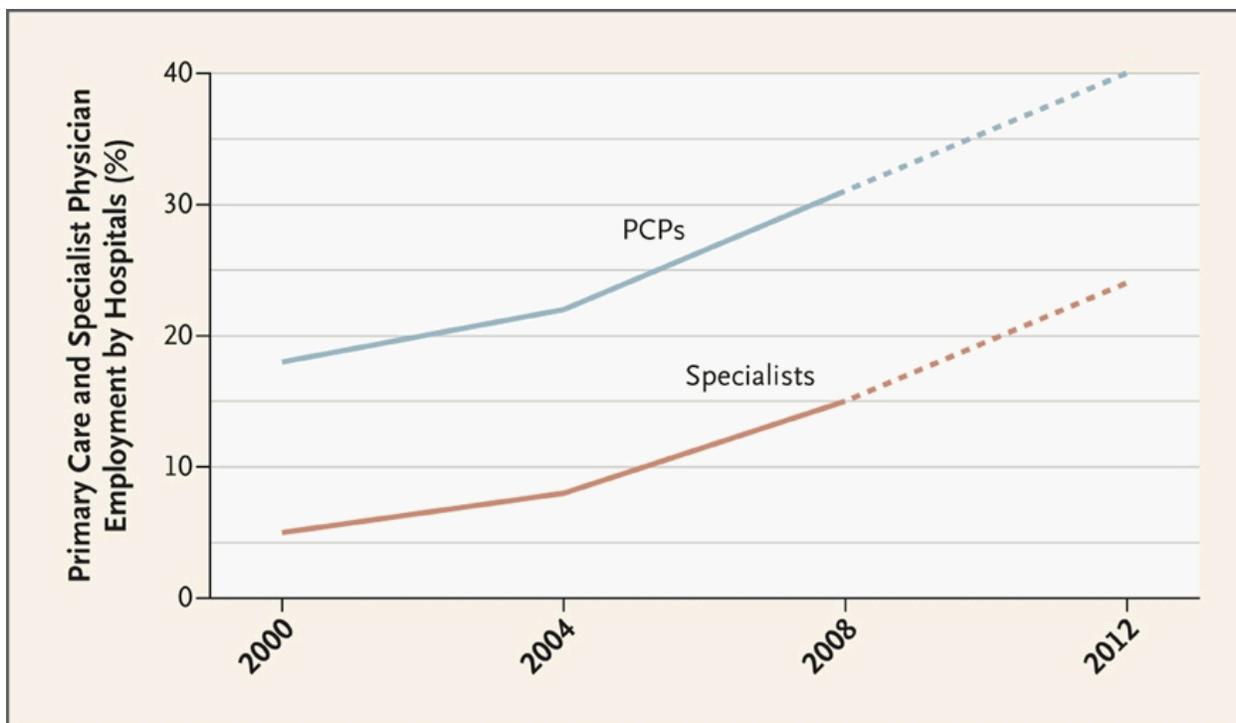
In 1987, the Washington Legislature enacted the Washington Peer Review Act, RCW 7.71, which created the "exclusive remedy for any action taken by a professional peer review body . . . that is found to be based on matters not related to the competence or professional conduct of a health care provider." RCW 7.71.030(1). The Act grants additional protections to those engaged in a peer-review action by creating a presumption of federal immunity, and the claimants' remedies are limited to "appropriate injunctive relief" and damages "only for lost earnings directly attributable to the action taken by the professional review body . . ." RCW 7.71.030(2). The Act also allows for attorney fees to the prevailing party. RCW 7.71.030(3).

This body of law, which was targeted to address issues in a system of independent physicians with medical staff privileges, still governs 30 years later. Although the laws have stayed the same, the landscape of the practice of medicine is changing rapidly, mostly to prepare for the 65th birthday of the baby boomers.

WHERE WE ARE: Employed Physicians

Currently, the political and social climate is driving physicians away from private practice and into employment with the hospital. In fact, over the past 25 years, the number of physicians in private practice has declined at an average of 2% every year. See Stephen L. Isaacs, J.D. et al., *The Independent Physician – Going, going . . .*, 360 N. ENG. J. MED., 655-657 (2009).





The driving force on the political side is the federal government's control of Medicare reimbursements. The 2010 health-care reform approved \$455 billion in spending cuts for Medicare over 10 years, but during those 10 years, the majority of the massive baby-boomer generation will turn 65 and many will depend on Medicare to pay their medical expenses. Therefore, the federal government must drastically cut Medicare reimbursements at a time when those reimbursements will constitute an increasingly greater percent of revenue for physicians.

This uncertainty makes employment within a hospital necessary, or at the very least, more attractive than private practice. Cardiologists, for example, are opting to become hospital employees because Medicare-reimbursement cuts are leading to the end of private-practice cardiology groups. See Steve Sternberg, *Cardiologists sue Sebelius over Medicare fee cuts*, USA TODAY (Dec. 28, 2009). This trend has hit Seattle—in the Seattle/Eastside area, there are only two remaining private practice cardiology groups; all other cardiology groups are employed by hospitals. Therefore, physicians increasingly are choosing the predictable salaries of employed physicians over facing the unpredictable effects of health-care reform.

Notably, hospitals are able to employ these physicians because all reimbursing payers, be it private insurance or Medicare, pay a premium reimbursement for all procedures performed at a hospital. The increased reimbursements reflect the higher cost of doing business of a hospital, accommodate charity care, and recognize the uncompensated administrative costs that hospitals face. Therefore, a hospital can afford to hire a physician, such as a cardiologist, because the hospital is paid more for the work performed by the physician at the hospital than the physician would have been paid for the same work in private practice.

When a hospital employs a physician, however, it creates another layer of legal rights and obligations as between the hospital and the physician that must be reconciled, if

possible. The hospital and the independent physician have preexisting legal rights and obligations under the medical-staff bylaws, policies, rules, and regulations, and when the physician becomes employed, he or she must reconcile those existing rights and obligations with new rights and obligations under the employment contract. Thus, for example, virtually all hospital-physician employment agreements provide for with- and without-cause termination, but it often is unclear what effect termination under either provision will have on the physician's medical-staff membership. This ambiguity sometimes can be addressed through a provision in the employment agreement stating that termination of employment will cause the physician to lose medical-staff privileges. But if the reason for the termination is clinical incompetence or poor professional conduct, the physician may have hearing rights under both the medical-staff bylaws and federal-immunity statutes. Although the physician may waive these rights, the waiver has to be express, and waiver of the right to a hearing under HCQIA should be expressly mentioned.

Additional problems can arise when an agreed-upon, without-cause termination of a physician-employment contract is used in a situation where there may be a conduct or clinical basis for the termination. Both state and federal law require hospitals to report instances in which a physician surrenders his or her privileges in exchange for an agreement by the hospital that it will not pursue an investigation or other proceedings concerning professional conduct or competence. A failure to report in this situation exposes the hospital to civil fines under state law and the potential of loss of immunity under federal law.

Finally, any surrender or withdrawal of privileges, in connection with termination of an employment contract or otherwise, after commencement of an investigation of clinical competence or professional conduct is reportable. But determining when an investigation has begun and when an investigation has ended for purposes of federal-reporting requirements can be difficult. *See, e.g., Costa v. Leavitt*, 442 F.Supp. 2d 754, 769-71 (Neb. 2006) (holding that the hospital improperly reported physician's surrender of privileges because investigation had not commenced); *Doe v. Leavitt*, 552 F.3d 75, 84 (1st Cir. 2009) (construing the word "investigation" for purposes of HCQIA without regard to definition of "investigation" in hospital's bylaws).

Another significant legal issue is that by employing physicians, hospitals are exposing themselves to employment discrimination lawsuits. In *Nassar v. Univ. of Texas Southwestern Medical Center*, No. 08-1337 (N.D. Tex. May 24, 2010), for example, a jury awarded more than \$3.6 million to an Egyptian-born employed physician who alleged he was forced to resign after race-based comments from another employed physician. The court also awarded the physician nearly \$500,000 in attorney fees.

Notably, otherwise privileged peer-review information may be used as evidence in an employment discrimination case in federal court. The Federal Rules of Civil Procedure will govern the scope of privilege, and allow parties to "obtain discovery regarding any non-privileged matter that is relevant to any party's claim or defense . . ." FRCP 26(b)(1). Therefore, courts may order production of peer-review documents if there is any possibility that the documents may lead to relevant information. *See Virmani v. Novant Health Corp.*, 259 F.3d 284 (4th Cir. 2006); *Sonnino v. University of Kansas Hosp. Authority*, 220 F.R.D. 633 (D. Kan. 2004); *Mattice v. Memorial Hosp. of S. Bend*, 203 F.R.D. 381 (N.D. Ind. 2001).

WHERE WE ARE GOING: Integrated Health-Care Networks

“The oldest members of the Baby Boom generation turn 65 in 2011 and will begin to swamp the struggling Medicare program with millions of new applicants. . . . The Baby Boom floodgate will stay open for the next two decades as more than 70 million Americans reach age 65.” – *New York Daily News*, January 1, 2011.

To reign in the cost of medical care, the federal government will cut reimbursement to hospitals and physicians. Therefore, hospitals and physicians will be forced to find ways to cut their own costs of providing medical care as the baby-boomer generation turns 65 and Medicare reimbursements are slashed to accommodate a drastic reduction in the Medicare budget. One appealing possibility is integrated health care networks, wherein otherwise competing health care providers and facilities join together to negotiate fee schedules with private insurance payers and negotiate bulk discount on medical supplies and equipment. Although this type of network typically would be a per se violation of anti-trust laws, the federal anti-trust agencies have agreed to consider the networks' price fixing under the "rule of reason" so long as the price fixing is ancillary to and reasonably necessary for a more efficient and cost-effective health-care-delivery system.

In exchange for the price-fixing pass, the federal anti-trust agencies want the networks to:

- (a) Develop and implement evidence-based clinical guideline or protocols;
- (b) Practice selective inclusion of providers in the network or network participation agreements that are sufficiently onerous that only health-care providers who are firmly committed will join the network;
- (c) Include a mechanism to collect and analyze treatment and outcome data for all providers to measure progress toward system goals and to identify high-cost and high-resource-utilization providers; and
- (d) Have a performance review committee separate from any hospital quality assurance committee or peer-review body to review the performance data, provide feedback to providers (via a “report card”), and to implement remedial action for performance outliers, including expulsion from the system.

See Federal Trade Commission Letter to Christi J. Braun, April 13, 2009, *available at* www.ftc.gov/os/closings/staff/090413tristatealetter.pdf.

Therefore, an employed physician potentially has to answer to the staff peer review bodies, hospital human resources, hospital credentialing, and, now, the network performance-review committee. But, physicians who do not opt in to the health care network will face the impending Medicare crisis without a reliable salary, the ability to negotiate costs, and the guaranteed inter-network referrals. This likely will lead to new legal issues, mainly due to the severe consequences of non-admission to or expulsion from the network. And, of course, the “performance-review committee” that decides expulsion based on a practitioner’s resource

utilization and costs will have no immunity under the existing laws that were established nearly 30 years ago.

It also is important to note that simply because the FTC may agree to evaluate the network under a "rule-of-reason" standard does not mean that expelled or nonadmitted physicians cannot independently sue the network. For example, in July 2009, an internal medicine physician in Clallam County, Dr. Robert Witham, filed a complaint against Clallam County Public Hospital (the "Hospital"), alleging that the Hospital had formed its own medical group, and that the physicians employed by the group were competing with the independent physicians in Clallam County. Complaint, Case No. 3:09-cv-05410, Dkt. 1, ¶¶ 26-27. Dr. Witham alleged that the Hospital's group monopolized and controlled the market for physician services in Clallam County. *Id.* Specifically, Dr. Witham alleged that the Hospital:

- (1) Violated Section 2 of the Sherman Antitrust Act, 15 U.S.C. § 2, by taking anticompetitive actions with intent to monopolize the relevant market;
- (2) Violated the Washington Consumer Protection Act ("WCPA"), RCW § 19.86.040, by monopolizing intrastate commerce for the provision of medical oncology services in Clallam County;
- (3) Violated the WCPA, RCW § 19.86.020, by committing unfair and deceptive actions to further its own economic interests at the expense of the plaintiff;
- (4) Tortiously interfered with plaintiff's business expectations from patients and referring physicians; and
- (5) Commercially disparaged the plaintiff by disseminating false statements about Dr. Witham to gain a competitive advantage. *Id.* at ¶¶ 19-26.

On October 15, 2009, the court dismissed plaintiff's claim against the Hospital for monetary damages under the antitrust laws and dismissed plaintiff's claims under the WCPA. *See* Order, Dkt. 15. The court held that, as a governmental entity, the hospital was immune from antitrust damages claims, and as a municipal corporation, the Hospital was statutorily exempt from the WCPA. *Id.* at 7-9. The parties then settled the remainder of the claims. A private health-care facility, however, likely would not have successfully dismissed the claims because that entity would not have immunity under the antitrust laws.

CONCLUSION

The physician that once had a private practice, staff privileges, and minimal oversight, now will be closely monitored, not only for competence and performance issues, but also for efficiency, cost, and resource utilization. Although integrated health-care networks are not developed or prominent enough to know exactly how they will operate and what unanticipated legal issues will arise, we clearly are on the precipice of using health-care networks to manage lower Medicare reimbursements while ensuring quality of patient care.

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JOHN J. NANCE

BIOGRAPHIC INFORMATION

John J. Nance, a native Texan who grew up in Dallas, holds a Bachelor's Degree from SMU and a Juris Doctor from SMU School of Law, and is a licensed attorney. Named Distinguished Alumni of SMU for 2002, and distinguish Alumni for Public Service of the SMU Dedman School of Law in 2010, he is also a decorated Air Force pilot veteran of Vietnam and Operations Desert Storm/Desert Shield and a Lt. Colonel in the USAF Reserve, well known for his involvement in Air Force human factors flight safety education, and one of the civilian pioneers of Crew Resource Management (CRM). John has piloted a wide variety of jet aircraft, including most of Boeing's line and the Air Force C-141, and has logged over 13,000 hours of flight time in his commercial airline and Air Force careers. He flies his own aircraft, was a veteran Boeing 737 Captain for Alaska Airlines, and is an internationally recognized air safety analyst and advocate, best known to North American television audiences as Aviation Analyst for ABC World News and Aviation Editor for Good Morning America.

John has logged countless appearances on national shows such as Larry King Live, PBS Hour with Jim Lehrer, Oprah, NPR, Nova, the Today Show, and many others. His editorials have been published in newspapers nationwide, including the Los Angeles Times and USA Today. He has long been listed in Who's Who in America, Who's Who in American Law, and Who's Who Among Emerging Leaders in America.

He is also the nationally-known author of 19 major books, five non-fiction: *Splash of Colors*, *Blind Trust*, *On Shaky Ground*, and *What Goes Up*, (all published by William Morrow), and *Golden Boy* (Eakin Press, 2003); plus 13 fiction bestsellers: *Final Approach* (Crown, 1990) NTSB investigator Joe Wallingford faces his own personal crises as he works through conflicts and cover-ups to arrive at the true cause of an airline disaster); *Scorpion Strike* (Crown, 1992) A military techno-thriller set after the first Gulf War); *Phoenix Rising* (Crown, 1994) A gripping novel of international airline finance and treachery); *Pandora's Clock* (Doubleday, 1995) A major New York Times Bestseller about a race against time with a doomsday virus threatening the world.; *Medusa's Child* (Doubleday, 1997) An edge-of-your-seat thriller about five people trapped aboard a cargo jet loaded with a ticking nuclear bomb which could destroy all the computers in North America.; *The Last Hostage* (Doubleday, 1998) An aggrieved father/airline captain hijacks his own airliner to force prosecution of the man he thinks killed his daughter, and rookie FBI negotiator Kat Bronsky has to try to talk him down to save over 130 lives - including her own.; *Blackout* (Putnam, 2000) FBI Special Agent Kat Bronsky is back and fighting for her life and the lives of seven survivors of a terrorist-caused accident; *Headwind* (Putnam, 2001) A real-life version of the Pinochet extradition case targeting a beloved ex-President of the U.S.;

Turbulence (Putnam, 2002) Disgusted passengers of a poorly run airline stage an airborne revolt at the wrong moment); Skyhook (Putnam, 2003) A "Black" Air Force project is threatened by sabotage as an airline captain fights to regain his license and discover what knocked his private airplane out of the sky over the Gulf of Alaska.; Fire Flight (Simon & Schuster, 2003) Two national parks are burning, but the aircraft needed to douse the fires are falling apart, and veteran pilot Clark Maxwell is faced with trying to find out why, and who's cheating, before more deaths occur.; Saving Cascadia (Simon & Schuster, 2005) As the Northwest corridor implodes in the aftermath of a devastating series of earthquakes, and a tsunami of near-apocalyptic proportions approaches, so begins the quest to rescue hundreds of stranded vacationers and islanders. Pandora's Clock and Medusa's Child both aired as major, successful two-part mini-series on television.

He is also the author of a major new book for American Healthcare entitled **WHY HOSPITALS SHOULD FLY** (SecondRiver Healthcare Press, 2009). The book, which is in a fictional format but highly accurate, has won the prestigious "Book of the Year" award for 2009 by the American College of Healthcare Executives.

John J. Nance is one of America's most dynamic professional speakers, presenting entertaining and pivotal programs on teamwork, risk management, motivation, coping with competition, and other topics to a wide variety of audiences, including business corporations and healthcare professionals. He and fellow author Kathleen Bartholomew (Ending Nurse-to-Nurse Hostility - Why Nurses Eat their Young and Each Other), present vital programs on Quality and Patient Safety to Hospital Boards, Physicians and Physician Leaders, and Hospital Management Nationally and Internationally. He is a pioneering and well-known advocate of using the lessons from the recent revolution in aviation safety to equally revolutionize the patient safety performance of hospitals, doctors, nurses, and all of healthcare.

John is a founding board member and a veteran member of the executive committee of the [National Patient Safety Foundation](#). He lives in Seattle, Washington.

Thomas H. Gallagher, MD

Thomas H. Gallagher, M.D., is a general internist who is an Associate Professor in the Department of Medicine and the Department of Bioethics and Humanities at the University of Washington. Dr. Gallagher received his medical degree from Harvard University, Cambridge, Massachusetts, completed his residency in Internal Medicine at Barnes Hospital, Washington University, St. Louis, and completed a fellowship in the Robert Wood Johnson Clinical Scholars Program, UCSF. Dr. Gallagher's research addresses the interfaces between healthcare quality, communication, and transparency.

Dr. Gallagher has published over 60 articles and book chapters on patient safety and error disclosure, which have appeared in leading journals including *JAMA*, *the New England Journal of Medicine*, and *Health Affairs*. He is the principal investigator on two grants from the Agency for Healthcare Research and Quality, including an AHRQ patient safety and medical liability demonstration project entitled "Communication to Prevent and Respond to Medical Injuries: WA State Collaborative." He also is principal investigator on grants from the National Cancer Institute, the Robert Wood Johnson Foundation, and the Greenwall Foundation.

Atul Gawande, MD, MPH

Atul Gawande is a surgeon, writer, and public health researcher. He practices general and endocrine surgery at Brigham and Women's Hospital in Boston. He is also Associate Professor of Surgery at Harvard Medical School and Associate Professor in the Department of Health Policy and Management at the Harvard School of Public Health. His research work currently focuses on systems innovations to transform safety and performance in surgery, childbirth, and care of the terminally ill.

He serves as lead advisor for the World Health Organization's Safe Surgery Saves Lives program. He is also founder and chairman of Lifebox, an international not-for-profit implementing systems and technologies to reduce surgical deaths globally. He has been a staff writer for the New Yorker magazine since 1998. He has written three New York Times bestselling books: *COMPLICATIONS*, which was a finalist for the National Book Award in 2002; *BETTER*, which was selected as one of the ten best books of 2007 by Amazon.com; and *THE CHECKLIST MANIFESTO*.

He has won two National Magazine Awards, AcademyHealth's Impact Award for highest research impact on health care, a MacArthur Award, and selection by Foreign Policy Magazine and TIME magazine as one of the world's top 100 influential thinkers.

Richard C. Boothman, JD

Mr. Boothman is the chief risk officer at the University of Michigan, where he designed and implemented their principled, proactive patient safety and claims resolution program, a program that is widely seen as the leading model nationally. Prior to coming to the University of Michigan, Mr. Boothman defended medical malpractice lawsuits for 22 years. He testified before the United States Senate in 2006 and detailed the University of Michigan's response to patient injuries and claims in the August 17, 2010, *Annals of Internal Medicine Journal*. Mr. Boothman holds degrees from the University of Michigan and the University of Detroit School of Law.

WA State HealthPact pilot project:

DISCLOSURE AND RESOLUTION PROGRAM

Improving the response to adverse events

August 25, 2011

9:15 a.m. – 10:45 a.m.

Washington Medical Quality Assurance Commission Meeting & Annual Workshop
Using National Research and Data to Enhance MQAC's Approach to Patient Safety

9:15 am – 9:25 am	The Disclosure and Resolution Program (DRP) Transparency, accountability and patient safety	Thomas Gallagher, MD Assoc. Professor, Medicine University of Washington
9:25 am – 9:30 am	Disclosure and Resolution Program Evaluation Using metrics to guide system improvements	Michelle Mello, JD, PhD Professor, Law & Public Health Harvard University
9:30 am – 9:50 am	The DRP in a Just Culture Moving towards a just response to adverse events	Atul Gawande, MPH, MD Assoc. Professor, Surgery Harvard Medical School
9:50 am – 10:05 am	Disclosure and Resolution Successes Lessons learned from the University of Michigan	Richard Boothman, JD Chief Risk Officer University of Michigan
10:05 am – 10:15 am	Questions	
10:15 am – 10:30 am	Stakeholder Perspectives Support from the continuum of healthcare	Stakeholder panel*
10:30 am – 10:40 am	Discussion	
10:40 am – 10:45 pm	Next Steps	

*Stakeholder panel

Brandelyn Bergstedt
Joel Cunningham, JD
Tim Layton, JD
Taya Briley, RN, MN, JD
Charles Meredith, MD
Mary-Lou Misrahy, BS, ARM
Ron Hofeldt, MD

Patient Advocate
Plaintiff attorney
Director, Legislative and Legal Affairs
General Legal Counsel
Medical Director
President
Director, Physician Affairs

Washington State Medical Association
Washington State Hospital Association
Washington Physicians Health Program
Physicians Insurance
Physicians Insurance

August 16, 2011

TO: Medical Quality Assurance Commission

FROM: Thomas H. Gallagher, MD, Principal Investigator

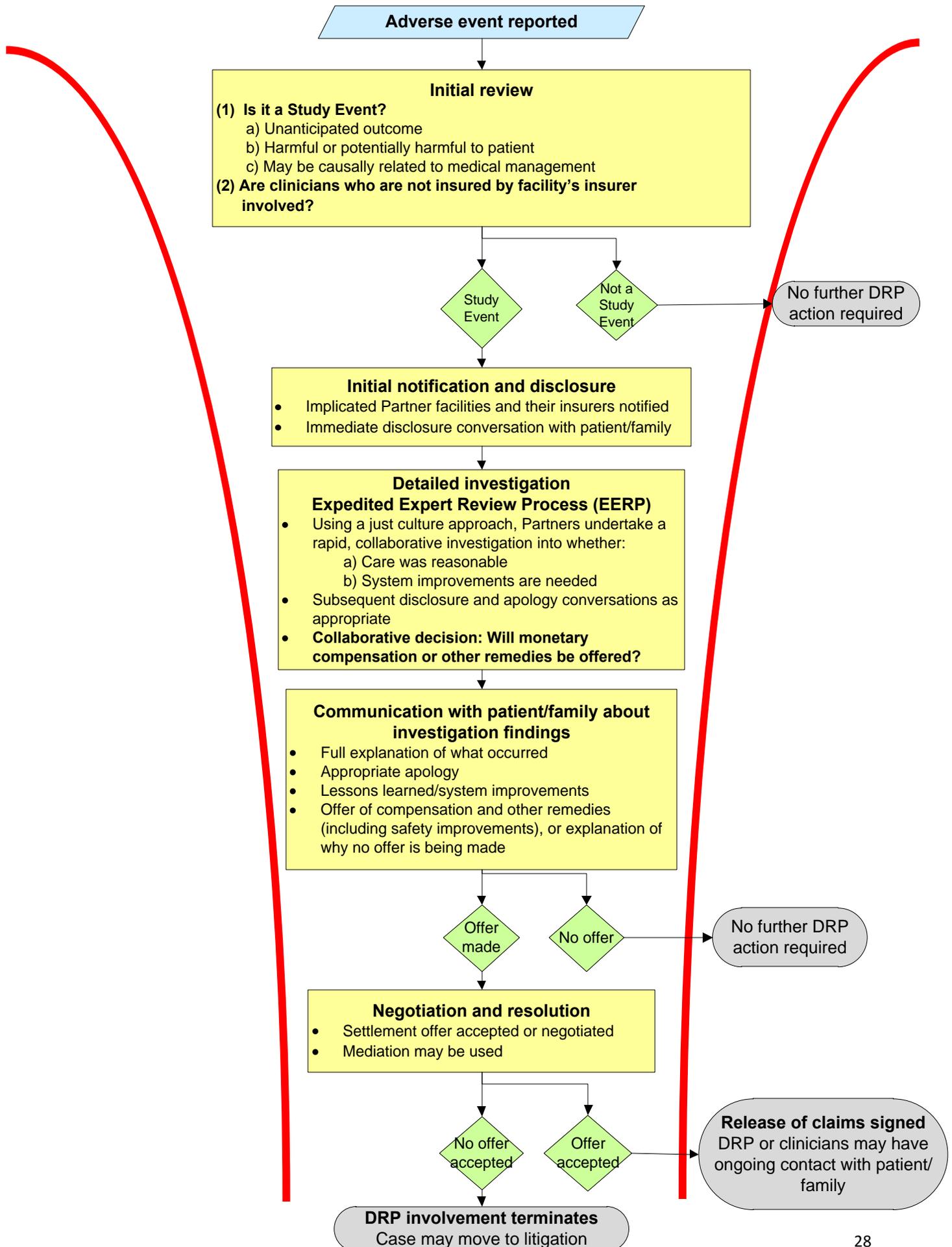
RE: Agency for Healthcare Research and Quality (AHRQ) Demonstration
Project: ***Communication to Prevent and Respond to Medical Injuries:
WA State Collaborative***

Disclosure and Resolution Program (DRP)

The AHRQ demonstration project includes development, implementation and evaluation of a disclosure and resolution program (DRP), a process for early investigation and enhanced communication between the health care team and patient after an adverse event. Physicians Insurance and five partner sites will collaborate on joint adverse event investigation, analysis, disclosure, and compensation for patients, when appropriate. The key elements of the DRP are nearly finalized; the attached DRP Funnel Diagram provides an overview of the process that hospitals and clinics, providers, and their insurers will use to respond collaboratively and promptly when an adverse patient outcome occurs. Stakeholders who agree to participate in the DRP will tailor their system policies to align with the DRP process.

ATTACHMENT: Disclosure and Resolution Program Funnel Diagram

The Disclosure and Resolution Program (DRP)



Kent E. Neff, MD, FAPA

Curriculum Vitae

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Portland, Oregon 97221

Tel: (503) 245-7111
Fax: (503) 292-6017
E-mail: kentneff@gmail.com

Education

Northwestern University, Evanston, Illinois	B.A. (Economics)	1961
University of Pennsylvania School of Medicine, Philadelphia	MD	1965
Oregon Health Sciences University, Portland, Oregon	Intern (Rotating)	1965-66
OHSU Department of Obstetrics & Gynecology	Resident	1968-69
OHSU Department of Psychiatry	Resident	1969-72
Boston University		
Certificate in Health Care Mediation & Conflict Resolution		1994

Academic Appointments/ Fellowships

Oregon Health Sciences University	Clinical Associate Professor, Psychiatry	
Timberlawn Psychiatric Hospital	Visiting Professor	1987
American Psychiatric Association	Distinguished Life Fellow	

Medical Licensure

Oregon, Washington
Tanzania (1967-68)

Current Work

Private practice primarily as consultant in health care, working with hospitals/health systems, medical groups, professional associations, state physician health programs, and professional licensing boards regarding physician health & wellness, problematic/disruptive behavior, patient safety & development of a Culture of Safety, effective team communication, group facilitation, mediation and conflict resolution. Perform organizational evaluations of departments experiencing problems. Give frequent lectures, seminars, retreats, and workshops throughout the United States and Canada on topics such as managing disruptive behavior in physicians, influencing physician behavior, physician/ professional health & wellness, establishing a respectful workplace, patient safety, healthy workplaces, managing change.

Health Care and Industry Consultant

1972-present

Consulted nationally to health care organizations and industry. Served as the consultant and leader in conceptualizing, developing, and opening three additional psychiatric/ mental health programs in general hospitals (Salem, OR; Vancouver, WA; Helena, MT). Assist health systems, hospitals, medical associations, licensing boards, and industry develop new programs or restructure existing ones. Frequently work with hospitals and physician groups in consultations, departmental evaluations, strategic planning, solving problems,

group facilitation, mediating disputes, improving medical staff- administration relationships, etc. Lead retreats & give presentations & seminars.

Director, Professional Assessment Program, Abbott Northwestern Hospital, Minneapolis, Minnesota 1994-2000

Reorganized and directed a comprehensive, multidisciplinary assessment program for physicians and other professionals with disruptive behavior, or behavioral or other problems. Physicians, other professionals, and executives were assessed in a week-long intensive program which received referrals from throughout the U.S and Canada.

Founder and CEO, Springbrook Institute, Inc. 1986-91

Conceptualized, raised \$3.5 million in private capital, and founded this addiction treatment center focusing on physicians, other professionals, and executives. Served as President and Chairman of the Board for this entrepreneurial venture during its early years.

Chairman, Oregon Medical Assn. Physicians Assistance Committee 1980-86
Director, Oregon Medical Assn. Monitored Treatment Program. 1982-86

Under the auspices of the Oregon Medical Association (OMA), conceptualized, developed, and managed the statewide program for troubled and impaired physicians. This included identification of these physicians, intervention, referral to treatment, managing the rehabilitation process, and extensive education of physicians and others throughout the state. This was done on a voluntary basis.

Conceptualized and developed the formal Monitored Treatment Program and managed this under contract with the OMA. The MTP improved the efficiency and effectiveness of the rehabilitation process for Oregon physicians and dentists in the early years of recovery. This program served as a model for several other states.

Director, Mental Health Services and Chief of Psychiatry
St. Vincent Hospital and Medical Center, Portland, Oregon 1979-82
Providence Hospital, Portland, Oregon 1972-78

Conceptualized, developed, and managed a new system of services in these large community tertiary teaching hospitals. Had full administrative responsibility for all aspects of the department: budget, hiring, annual reviews, personnel, policies & procedures, etc.. This included programs to meet a wide range of needs, including consultation/ liaison services for medical & surgical patients as well as inpatient and outpatient services for psychiatric patients. Developed and supervised a training program and two-month psychiatry rotation for internal medicine residents. Served on the hospital board, numerous hospital committees and task forces. Provided ongoing consultation to the Medical Staff and administration across this large health system on problems involving physician behavior, program development, interdepartmental communication, teamwork, and mediation/ conflict resolution.

Medical Officer, U. S. Public Health Service/ Peace Corps 1966-68
1970

Practiced general medicine and supervised medical team and public health workers in Africa (Tanzania, Niger) and Korea for 2 ½ years.

Selected Presentations, Publications, Awards

Hazelden Springbrook C.A.R.E. Award (2010)

Voluntary Hospitals of America (VHA) national webcast on understanding and managing physician disruptive behavior in hospitals. (2006)

Understanding and Managing Disruptive Behavior in Physicians, Chapter 4 in *Enhancing Physician Behavior: Advanced Principles of Medical Management*, American College of Physician Executives, 2000.

How (and Why) to Manage Disruptive Doctors, *The Medical Economics Audio Digest*, Volume 2, Issue 6, June, 1999.

Two Hundred Physicians Referred for Disruptive Behavior: Findings and Implications for Reducing Errors in Health Care, in *Enhancing Patient Safety and Reducing Errors in Health Care (Proceedings of the National Patient Safety Conference at Annenberg*, California, November, 1998.

“Searching for a New Paradigm in Health Care Delivery,” Neff, Kent E. and Moser, Dennis R., in *Physician Executive*, March/ April 1993.

Ecumenical Service Award, Oregon Ecumenical Ministries, 1990.

Distinguished Service Award, Multnomah County Medical Society, (for work with physicians), 1985

Presidential Citation, Oregon Medical Assoc. (for work with physicians), 1984

Numerous consultations, seminars & presentations throughout the U.S. and Canada, including:

Administrators in Medicine	Ohio Physicians Health Program
Alberta College of Physicians & Surgeons	American Medical Association
American College of Surgeons	The Marshfield Clinic
American Psychiatric Association	Washington State Medical Assn.
British Columbia College of Physicians	West Virginia Hospital Assn.
Federation of State Medical Licensing Bds.	US Bank
The Foundation for Medical Excellence	Wyoming Medical Board
The Mayo Clinic	Ministry Health Care (Wisconsin)
American College of Obstetrics & Gynecology	Colorado Board of Medical Examiners
Medical Group Management Association	UNUM Insurance Company
Saskatchewan Council of Medical Directors	Washington Physicians Health Pgm.
Federation of State Medical Licensing Boards	
Stanford University Department on Psychiatry & the Law	
Clearinghouse for Licensing, Enforcement, & Regulation (CLEAR)	

WHEN GOOD DOCTORS GO BAD

What happens when trusted physicians begin to hurt their patients?

BY ATUL GAWANDE

Hank Goodman is a former orthopedic surgeon. He is fifty-six years old and stands six feet one, with thick, tousled brown hair and outsized hands that you can easily imagine snapping a knee back into place. He is calm and confident, a man used to fixing bone. At one time, before his license was taken away, he was a highly respected and sought-after surgeon. "He could do some of the best, most brilliant work around," one of his orthopedic partners told me. When other doctors needed an orthopedist for family and friends, they called on him. Over a decade and a half, Goodman came to be among the busiest surgeons in his state. Along the way, however, things started to go wrong. He cut corners, got sloppy. Patients were hurt. Colleagues who had once admired him grew appalled. And still it was years before he was stopped.

When people talk about bad doctors, they usually talk about the monsters. We hear about doctors like Harold Shipman, the physician from the North of England who was recently convicted of murdering fifteen patients with lethal doses of narcotics. Or John Ronald Brown, a San Diego surgeon who, working without a license, bungled a series of sex-change operations, and amputated the left leg of a perfectly healthy man, who then died of gangrene. Or James Burt, a notorious Ohio gynecologist who subjected hundreds of women, often after they had been anesthetized for other procedures, to a bizarre, disfiguring operation involving clitoral circumcision and vaginal "reshaping," which he called the Surgery of Love.

But the real problem isn't these frightening aberrations. It is what you might call the everyday bad doctors, like Hank Goodman. In medicine, we all come to know such doctors: the illustrious cardiologist who has slowly gone senile and won't retire; the long-respected obstetri-

cian with a drinking problem; the surgeon who has somehow lost his touch. Good doctors can go bad, and when they do the medical profession is almost entirely unequipped to do anything about it.

Goodman and I talked over the course of a year. He sounded as baffled as anyone by what had become of him, but he agreed to tell his story so that others could learn from his experience. He even put me in touch with former colleagues and patients. His only request was that I not use his real name.

One case began on a hot August day in 1991. Goodman was at the hospital—a sprawling, modern, floodlit complex, with a towering red brick building at its center, surrounded by several smaller facilities, all fed by an extensive network of outlying clinics and a nearby medical school. Situated off a long corridor on the ground floor of the main building were the operating rooms, with their white-tiled, wide-open spaces, the patients laid out, each under a canopy of lights, and teams of blue-clad people going about their business. In one of these rooms, Goodman finished an operation, pulled off his gown, and went over to a wall phone to respond to his messages while waiting for the room to be cleaned. One was from his physician assistant, at the office, half a block away. He wanted to talk to Goodman about Mrs. D.

Mrs. D. was twenty-eight years old, a mother of two, and the wife of the business manager of a local auto-body shop. She had originally come to Goodman about a painless but persistent fluid swelling on her knee. He had advised surgery, and she had agreed to it. The week before, he had done an operation to remove the fluid. But now, the assistant reported, she was back; she felt feverish and ill, and her knee was intolerably painful. On examination, he told

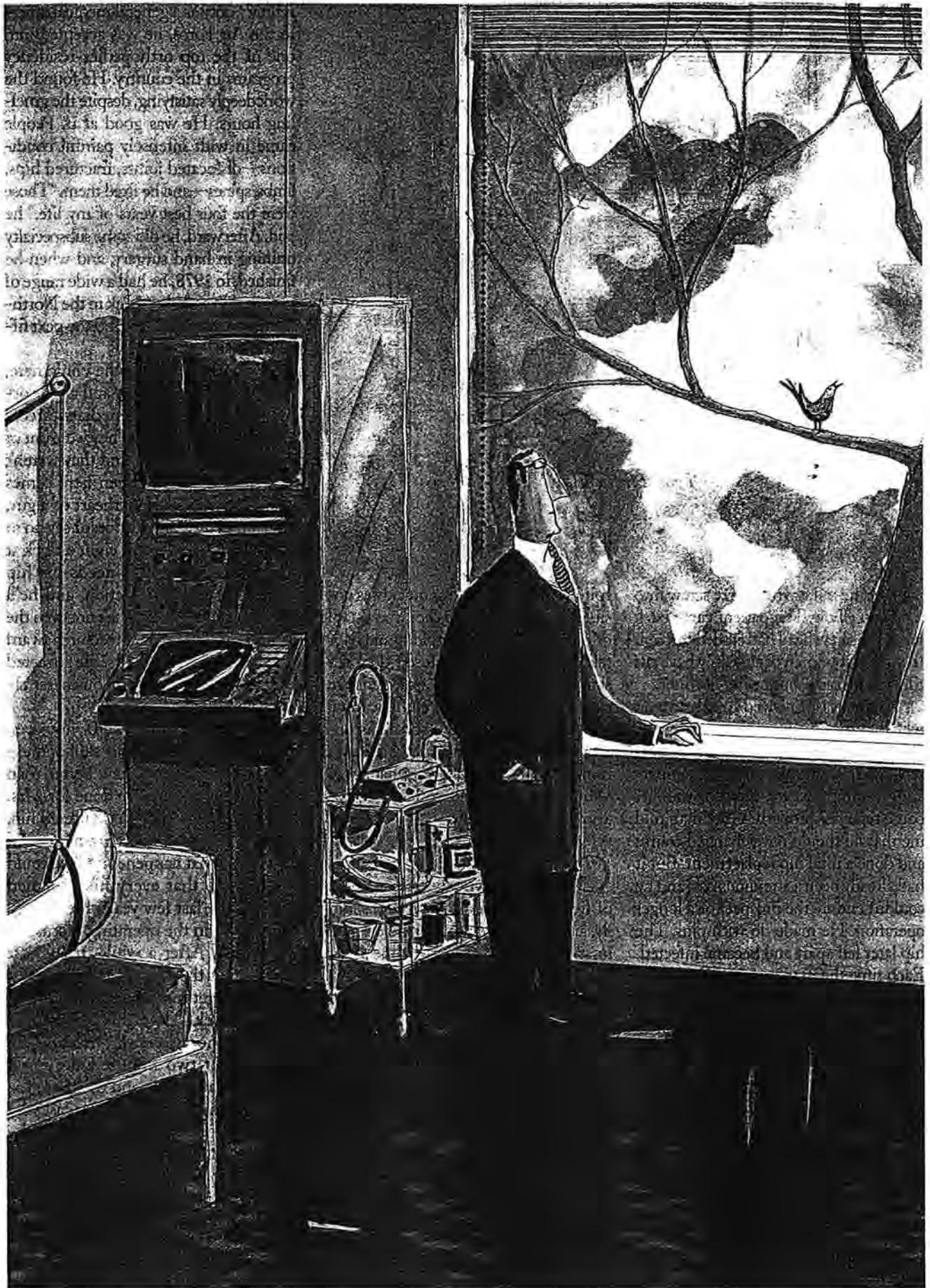
Goodman, the knee was red, hot, and tender. When he put a needle into the joint, foul-smelling pus came out. What should he do?

It was clear from this description that the woman was suffering from a disastrous infection, that she had to have the knee opened and drained as soon as possible. But Goodman was busy, and he never considered the idea. He didn't bring her into the hospital. He didn't go to see her. He didn't even have a colleague see her. Send her out on oral antibiotics, he said. The assistant expressed some doubt, to which Goodman responded, "Ah, she's just a whiner."

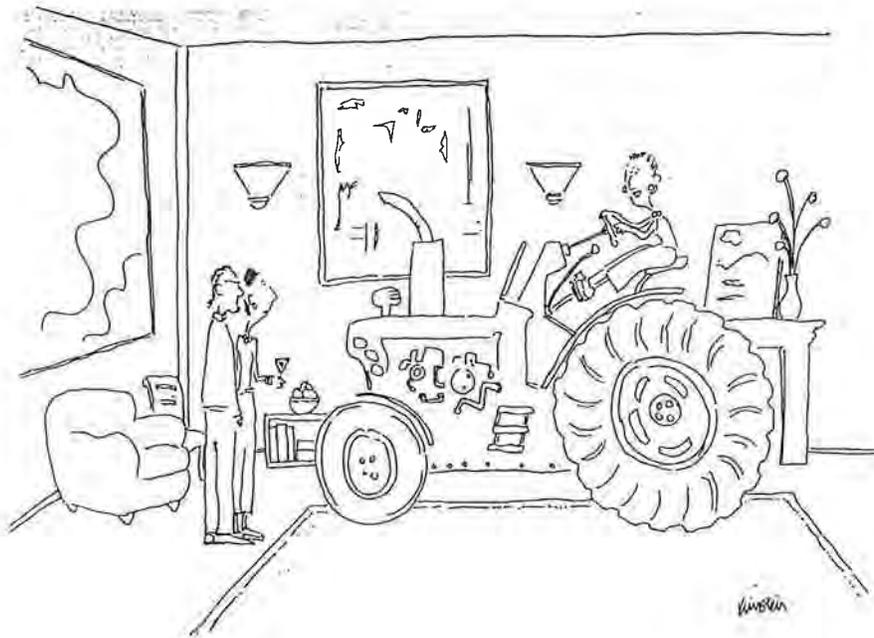
A week later, the patient came back, and Goodman finally drained her knee. But it was too late. The infection had consumed the cartilage. Her entire joint was destroyed. Later, she saw another orthopedist, but all he could do was fuse her knee solid to stop the constant pain of bone rubbing against bone.

When I spoke to her, she sounded remarkably philosophical. "I've adapted," she told me. With a solid knee, though, she said she can't run, can't bend down to pick up a child. She took several falls down the stairs of her split-level home, and she and her family had to move to a ranch-style house for safety's sake. She cannot sit on airplanes. In movie theatres, she has to sit sideways on an aisle. Not long ago, she went to see a doctor about getting an artificial knee, but she was told that, because of the previous damage, it couldn't safely be done.

Every physician is capable of making a dumb, cavalier decision like Goodman's, but in his last few years of practice he made them over and over again. In one case, he put the wrong-size screw into a patient's broken ankle, and didn't notice that the screw had gone in too deep. When the patient complained of pain, Goodman refused to admit that anything needed to be done. In a sim-



We like to think of "problem doctors" as aberrations; the aberrations may be those who make it without a troubled year or two.



"I got it from eBay."

ilar case, he put a wrong-size screw into a broken elbow. The patient came back when the screw head had eroded through the skin. Goodman could easily have cut the screw to size, but he did nothing.

Another case involved an elderly man who'd come in with a broken hip. It looked as if he would need only a few pins to repair the fracture. In the operating room, however, the hip wouldn't come together properly. Goodman told me that he should have changed course and done a total hip replacement. But it had already been a strenuous day, and he couldn't endure the prospect of a longer operation. He made do with pins. The hip later fell apart and became infected. Each time the man came in, Goodman insisted there was nothing to be done. In time, the bone almost completely dissolved. Finally, the patient went to one of Goodman's colleagues for a second opinion. The colleague was horrified by what he found. "He ignored this patient's pleas for help," the surgeon told me. "He just wouldn't do anything. He literally wouldn't bring the patient into the hospital. He ignored the obvious on X-rays. He could have killed this guy the way things were going."

For the last several years that Goodman was in practice, he was the defendant in a stream of malpractice suits, de-

spite settling each one as quickly as possible. His botched cases became a staple of his department's Morbidity and Mortality conferences, the closed-door sessions in which doctors are expected to review their mistakes and complications.

Sitting with him over breakfast in a corner of a downtown restaurant, I asked him how all this could have happened. Words seemed to elude him. "I don't know," he said faintly.

Goodman grew up in a small northwestern town, the second child of five in an electrical contractor's family, and neither he nor anyone else ever imagined that he might become a doctor. In college, a local state university, he was at first an aimless, mediocre student. Then one night he was up late drinking coffee, smoking cigarettes, and taking notes for a paper on Henry James when it came to him: "I said to myself, 'You know, I think I'll go into medicine.'" It was not exactly an inspiration, he said. "I just came to a decision without much foundation I could ever see." A minister once told him that it sounded "more like a call than I ever got."

Goodman became a dedicated student, got into an excellent medical school, and headed for a career in surgery after graduation. After completing

military duty as a general medical officer in the Air Force, he was accepted into one of the top orthopedics-residency programs in the country. He found the work deeply satisfying, despite the grueling hours. He was good at it. People came in with intensely painful conditions—dislocated joints, fractured hips, limbs, spines—and he fixed them. "Those were the four best years of my life," he said. Afterward, he did some subspecialty training in hand surgery, and when he finished, in 1978, he had a wide range of choices. He ended up back in the Northwest, where he would spend the next fifteen years.

"When he came to the clinic here, we had three older, rusty and crusty orthopedic surgeons," a pediatrics colleague of his told me. "They were out of date and out of touch, and they weren't very nice to people. Then here comes this fellow, who's a sweetheart of a guy, more up to date, and he doesn't say no to anybody. You call him at eight o'clock at night with a kid who needs his hip tapped because of infection, and he'll come in and do it—and he's not even the one on call." He won a teaching award from his medical students. He attracted a phenomenal amount of business. He revelled in the job.

Sometime around 1990, however, things changed. With his skill and experience, Goodman knew better than most what needed to be done for Mrs. D., for the man with the shattered hip, and for many other patients, but he did not do it. What happened? All he could tell me was that everything seemed wrong those last few years. He used to enjoy being in the operating room, fixing people. After a while, though, it seemed that the only thing he thought about was getting through all his patients as quickly as possible.

Was money part of the problem? He made about two hundred thousand dollars a year at first, and the more patients he saw and the more cases he took the more money he made. Pushing himself, he found that he could make three hundred thousand dollars. Pushing himself even harder, until he was handling a dizzying number of cases, he made four hundred thousand dollars. He was far busier than any of his partners, and that fact increasingly became, in his mind, a key measure of

his worth. He began to call himself, only half in jest, "the Producer." More than one colleague mentioned to me that he had become fixated on his status as the No. 1 booker.

His sense of himself as a professional also made him unwilling to turn people away. (He was, after all, the guy who never said no.) Whatever the cause, his caseload had clearly become overwhelming. He'd been working eighty, ninety, a hundred hours a week for well over a decade. He had a wife and three children—the children are grown now—but he didn't see much of them. His schedule was packed tight, and he needed absolute efficiency to get through it all. He'd begin with, say, a total hip replacement at 7:30 A.M. and try to finish in two hours or so. Then he'd pull off his gown, tear through the paperwork, and, as the room was being cleaned, stride out the main tower doors, into the sun, or snow, or rain, over to the outpatient-surgery unit, half a block away. He'd have another patient waiting on the table there—a simple case, maybe a knee arthroscopy or a carpal-tunnel release. Near the end, he'd signal a nurse to call ahead and have the next patient wheeled into the O.R. back in the main tower. He'd close skin on the second case and then bolt back for a third. He went back and forth all day. Yet, no matter what he did to keep up, unforeseen difficulties arose—a delay in getting a room ready, a new patient in the emergency room, an unexpected problem in an operation. Over time, he came to find the snags unbearable. That's undoubtedly when things became dangerous. Medicine requires the fortitude to take what comes: your schedule may be packed, the hour late, your child waiting for you to pick him up after swimming practice; but if a problem arises you have to do what is necessary. Time after time, Goodman failed to do so.

This sort of burnout is surprisingly common. Doctors are supposed to be tougher, steadier, better able to handle pressure than most. (Don't the rigors of medical training weed out the weak ones?) But the evidence suggests otherwise. Studies show, for example, that alcoholism is no less common among doctors than among other people. Doctors are more likely to be-

come addicted to prescription narcotics and tranquilizers, presumably because we have such easy access to them. Some thirty-two per cent of the general working-age population develops at least one serious mental disorder—such as major depression, mania, panic disorder, psychosis, or addiction—and there is no evidence that such disorders are any less common among doctors. And, of course, doctors become ill, old, and disaffected or distracted by their own difficulties, and for these and similar reasons they falter in their care of patients. We'd all like to think of "problem doctors" as aberrations. The aberration may be a doctor who makes it through a forty-year career without at least a troubled year or two. Not everyone with "problems" is necessarily dangerous, of course. Nonetheless, at any given time, an estimated three to five per cent of practicing physicians are actually unfit to see patients.

There's an official line about how the medical profession is supposed to deal

with these physicians: colleagues are expected to join forces promptly to remove them from practice and report them to the medical-licensing authorities, who, in turn, are supposed to discipline them or expel them from the profession. It hardly ever happens that way. Marilyn Rosenthal, a sociologist at the University of Michigan, has examined how medical communities in the United States, Great Britain, and Sweden deal with problem physicians. She has gathered data on what happened in more than two hundred specific cases, ranging from a family physician with a barbiturate addiction to a fifty-three-year-old cardiac surgeon who continued operating despite permanent cerebral damage from a stroke. And nearly everywhere she looked she found the same thing. It was a matter of months, even years, before colleagues took effective action against a bad doctor, however dangerous his or her conduct might have been.

People have called this a conspiracy of



"Oh, just picking up the pieces of my life after a really traumatic haircut."

silence; but Rosenthal did not find plotting so much as a sorry lack of it. In the medical communities she observed, the dominant reaction was uncertainty, denial, and dithering, feckless intervention. This won't come as a surprise to members of the medical profession. For one thing, although everyone may "know" that Dr. So-and-So drinks too much or has become "too old," certainty can remain elusive.

Even when the problems are obvious, colleagues can take a long time before doing anything decisive. There are both honorable and dishonorable reasons for this. The dishonorable reason is that doing nothing is easy. It takes an enormous amount of work and self-assurance to gather from colleagues the evidence and the votes that are needed to suspend another doctor's privileges to practice. The honorable reason, and probably the main reason, is that no one really has the heart for it. When a skilled, decent, ordinarily conscientious colleague, whom you've known and worked with for years, starts popping Percodans, or becomes preoc-

cupied with personal problems, and neglects the proper care of his patients, you want to help, not destroy the doctor's career. In private practice, there are no sabbaticals to offer, no leaves of absence, only disciplinary proceedings and public reports of misdeeds. As a consequence, people try to help, but they do it quietly, privately. Their intentions are good; the result usually isn't.

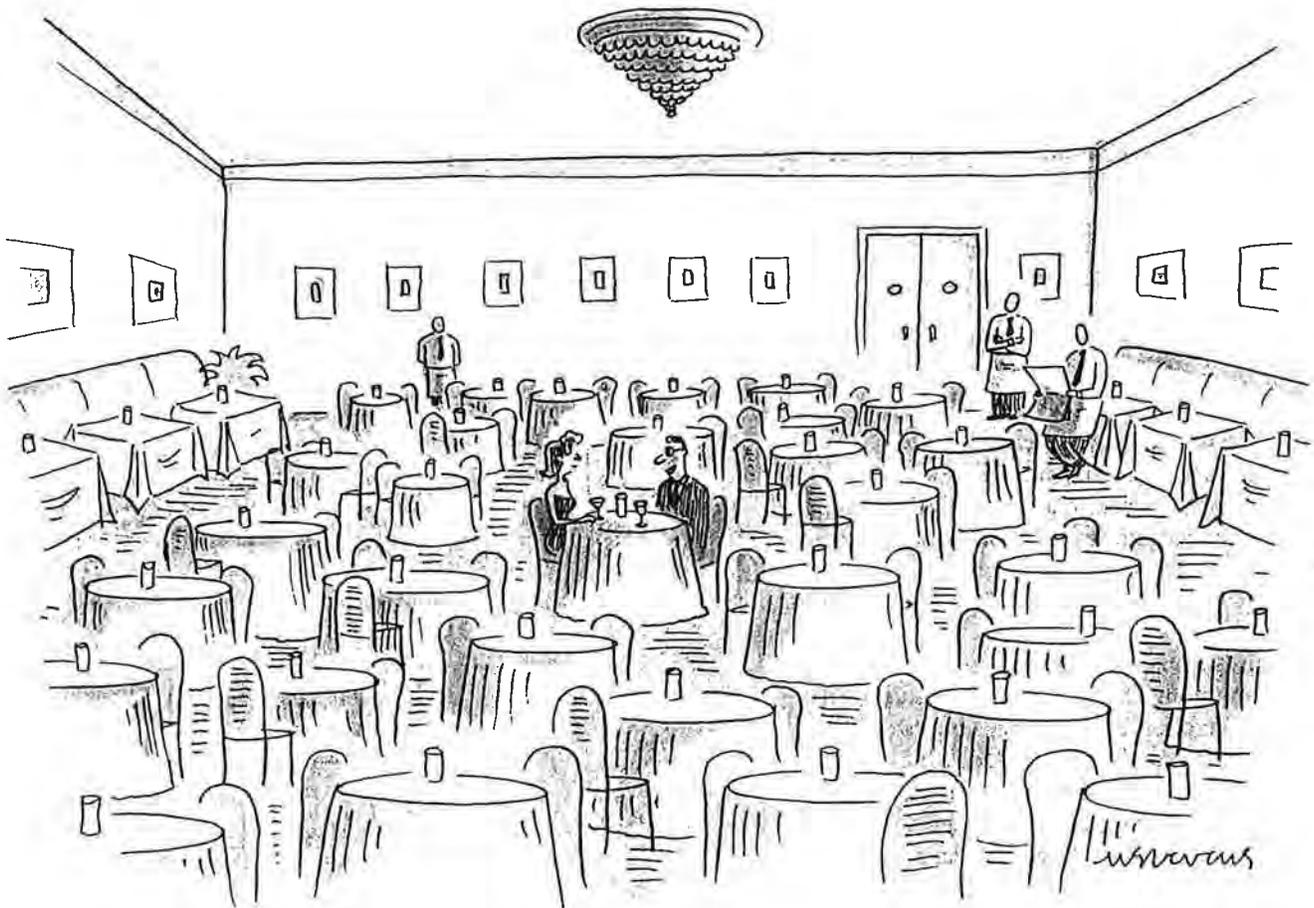
For a long time, Hank Goodman's colleagues tried to help him. Starting around 1990, they began to have suspicions. There was talk of the bizarre decisions, the dubious complications, a growing number of lawsuits. More and more, people felt the need to step in.

A few of the older physicians, each acting on his own, took him aside at one point or another. Rosenthal calls this the Terribly Quiet Chat. A partner would see Goodman at a cocktail party or just happen to drop by his home. He'd pull Goodman aside, ask how he was doing, tell him that people had con-

cerns. Another took the tough-love approach: "I said to him straight out, 'I don't know what makes you tick. Your behavior is totally bizarre. The scary thing is I wouldn't let my family members go near you.'"

Sometimes this approach can work. I spoke to a retired department head at Harvard who had initiated more than a few Terribly Quiet Chats. A senior physician can have forbidding moral authority in medicine. Many wayward doctors whom the department head confronted confessed to having troubles, and he did what he could to help. He'd arrange to have them see a psychiatrist, or go to a drug-rehab center, or retire. But some doctors didn't follow through. Others denied that anything was wrong. A few went so far as to mount small campaigns in their defense. They would have family members call him in outrage, loyal colleagues stop him in the hospital halls to say they'd never seen any wrongdoing, lawyers threaten to sue.

Goodman did listen to what people



"This place is one of New York's best-kept secrets."

had to say. He nodded and confessed that he felt overworked, at times overwhelmed. He vowed to make changes, to accept fewer cases and stop rushing through them, to perform surgery as he knew it should be performed. He would walk away mortified, resolving to mend his ways. But in the end nothing changed.

As is often the case, the people who were in the best position to see how dangerous Goodman had become were in the worst position to do anything about it: junior physicians, nurses, ancillary staff. In such circumstances, the support staff will often take measures to protect patients. Nurses find themselves quietly directing patients to other doctors. Receptionists suddenly have trouble finding openings in a doctor's schedule. Senior surgical residents scrub in on junior-level operations to make sure a particular surgeon doesn't do anything harmful.

In one case, the junior colleagues of a professor of internal medicine went so far as to review, in secret, virtually every decision he made. The internist was a doctor of exquisite skill and judgment, a nationally known figure who had taught a generation of young doctors. But then his wife became ill with breast cancer, and during a four-year battle that ended in her death he grew discouraged and listless. He made mistakes: in one patient he missed a thyroid mass, in another a heart murmur. Concerned about what was happening, colleagues began looking through his charts, first randomly and then, when they saw the number of errors, systematically. They ordered the medicines he should have ordered, admitted the patients he should have admitted, conducted complete diagnostic workups in his name. Each day, after the professor left his clinic, they would review all his decisions with the nurses to find the lapses and fix them. They continued to intervene until his ordeal was over and he regained his clinical acumen.

One of Goodman's physician assistants tried to take on this protective role. When he first began working with Goodman—helping to set fractures, following patients' progress, and assisting in the operating room—he revered the man. But he noticed when Goodman became erratic. "He'd run

through forty patients in a day and not spend five minutes with them," the assistant told me. To avert problems in the clinic, he stayed late after hours, double-checking Goodman's decisions. "I was constantly following up with patients and changing what he did for them." In the operating room, he tried to make gentle suggestions. "Is that screw too long?" he might ask. "Does the alignment on that hip look right?" There were nonetheless mistakes, and "a lot of unnecessary surgery," he said. When he could, he steered patients away from Goodman—"though without actually coming out and saying, 'I think he's crazy.'"

Matters can drift along this way for a remarkably long time. But when someone has exhausted all reservoirs of good will—when the Terribly Quiet Chats are clearly going nowhere and there seems to be no end to the behind-the-scenes work colleagues have to do—the mood can change swiftly. The smallest matter can precipitate drastic action. With Goodman, it was skipping the mandatory weekly Morbidity and Mortality conferences, which he started to do in late 1993. As negligent as his patient care could be—he had become one of the hospital's most frequently sued doctors—people remained uncomfortable about judging him. When Goodman stopped attending M. & M.s, however, his colleagues finally had a concrete violation to confront him with.

Various people warned him, with increasing sharpness, that he would be in serious trouble if he didn't start showing up at M. & M.s. "But he ignored them all," a colleague of his told me. In late 1994, when he still didn't show up, the hospital board put him on probation. Through all this, he was operating on more patients and generating ever more complications. And still a whole year went by. Soon after Labor Day of 1995, the board and its lawyer finally sat him down at the end of a long conference table and told him that they were suspending his operating privileges and referring his conduct to the state medical board for investigation. He was fired.

Goodman had never let on to his family about his difficulties, and he didn't tell them when he'd lost his job.

Each morning for weeks, he put on a suit and tie and went to his office, as if nothing had changed. He saw the last of his scheduled patients, and referred those who needed an operation to others. His practice dried up within a month. His wife sensed that something was wrong, and he finally told her. She was floored, and frightened: she felt as if he were a stranger, an impostor. After that, he just stayed home in bed. He spoke to no one for days at a time.

Two months after his suspension, Goodman was notified of another malpractice suit, this one on behalf of a farmer's wife who had come to him with a severely arthritic shoulder. He had put in an artificial joint, but the repair failed. The lawsuit was the last straw. "I had nothing," he told me. "I had friends and family, yes, but no job." As with many doctors, his job was his identity.

In his basement den, he had a gun, a .44 Magnum that he had bought for a fishing trip to Alaska, to protect him against bears. He found the bullets for the gun and contemplated suicide. He knew how to do it so that his death would be instantaneous. He was, after all, a surgeon.

Two years ago, I was at a medical conference near Palm Springs, skimming through the dense lecture schedule, when an unusual presentation caught my eye: "Two Hundred Physicians Reported for Disruptive Behavior," by Kent Neff, M.D. The lecture was in a small classroom away from the main lecture hall. At most, a few dozen people attended. Neff was fifty-ish, trim, silver-haired, and earnest, and he turned out to have what must be the most closeted subspecialty in medicine: he was a psychiatrist specializing in doctors and other professionals with serious behavioral problems. In 1994, he told us, he had taken charge of a small program to help hospitals and medical groups with troubled doctors. Before long, they were sending him doctors from all over. To date, he'd seen more than two hundred and fifty, a remarkable wealth of experience, and he went through the data he'd collected like a C.D.C. scientist analyzing an outbreak of tuberculosis.

What he found was unsurprising. The doctors were often not recognized

to be dangerous until they had done considerable damage. They were rarely given a thorough evaluation for addiction, mental illness, or other typical afflictions. And, when problems *were* identified, the follow-through was abysmal. What impressed me was Neff's single-handed, quixotic attempt—he had no grants, no assistance from government agencies—to do something about this.

A few months after the lecture, I flew to Minneapolis to see Neff in action. His program was at Abbott Northwestern Hospital, near the city's Powderhorn district. When I arrived, I was directed to the fifth floor of a brick building discreetly off to one side of the main hospital complex. There I found a long, dimly lit hallway with closed, unmarked doors on both sides and beige, low-pile carpeting. It looked nothing like a hospital. A block-lettered sign read "Professional Assessment Program." Neff, in a tweed jacket and metal-rimmed glasses, came out of one of the doors and showed me around.

Each Sunday night, the physicians arrived here, suitcases in hand. They checked in down the hall and were shown to dormitory-style rooms where they would stay for four days and four nights. Three doctor-patients were staying during the week that I visited. They were permitted to come and go as they pleased, Neff assured me. Yet I knew that they were not quite free. In most cases, their hospitals had paid a fee of seven thousand dollars, telling them that if they wanted to keep their practices they had to go to Minneapolis.

The most striking aspect of the program, it seemed to me, was that Neff had actually persuaded medical organizations to send the doctors. He had done this, it seemed, by simply offering to help. For all their dithering, hospitals and clinics turned out to be eager for Neff's help. And they weren't the only ones. Before long, airlines began sending him pilots. Courts sent him judges. Companies sent him C.E.O.s.

A small part of what Neff did was just meddle. He was like one of those doctors whom you consult about a coughing child, and who then tell you how to run your life. He'd take the doctors in hand, but he was not shy about telling organizations when they had

let a problem fester, too long. There are certain kinds of behavior—what he called "behavioral sentinel events"—that should alert people that something may be seriously wrong with a person, he explained to me. For example, a surgeon throws scalpels in the O.R., or a pilot bursts into uncontrolled rages in mid-flight. Yet, in case after case, such episodes are shrugged off. "He's a fine doctor," people will say, "but sometimes he has his moments."

Neff recognizes at least four types of behavioral sentinel events. There is persistent, poor anger control or abusive behavior. There is bizarre or erratic behavior. (He saw a doctor who could not get through the day without spending a couple of hours arranging and rearranging his desk. The doctor was found to have severe obsessive-compulsive disorder.) There is transgression of proper professional boundaries. (Neff once saw a family physician who was known to take young male patients out alone for dinner and, in one instance, on vacation with him. He turned out to have compulsive fantasies of sex with pubescent boys.) And there is the more familiar marker of incurring a disproportionate number of lawsuits or complaints (as Goodman had). Through his program, Neff has persuaded a substantial number of hospitals and clinics—and airlines and corporations—to take such events seriously. Many organizations have now specified, as a part of their contracts, that behavioral sentinel events could trigger an evaluation.

The essence of what he did, however, was simply provide a patient consultation, the way a cardiologist might provide a consultation about someone's chest pains. He examined the person sent to him, performed some tests, and gave a formal opinion about what was going on, about whether the person could safely be kept on the job, and about how things might be turned around. Neff was willing to do what everyone else was extremely reluctant to do: to judge (or, as he prefers to say, to "assess") a fellow-doctor. And he did it more thoroughly and dispassionately than a physician's colleagues ever could.

The week that I was there, Neff first gathered information on each of the three doctor-patients' cases. Starting on Monday morning, and through-

SHOWCASE BY
DANA LIXENBERG

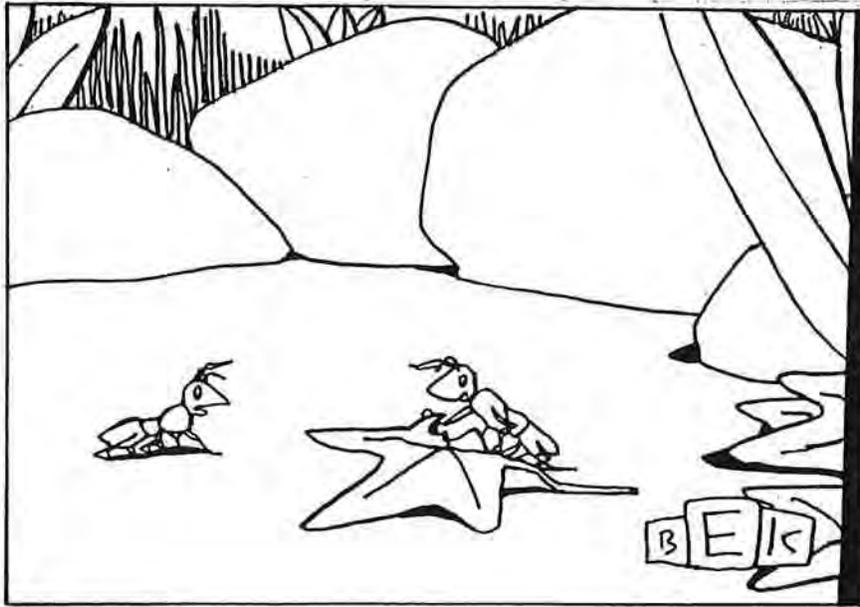
SMART SET

Nine years ago, when two Brooklyn kids—Keeth Smart and his sister Erinn—first walked into the New York Fencers' Club, they had no idea that learning how to fence would change their lives. "I didn't know a thing about it, other than the basics from 'Zorro,'" Keeth, who was twelve at the time, recalls. Erinn, who was ten, says, "I was attracted to the fact that you had to use footwork and handwork at the same time." Every week, and then every day, the Smarts returned to the club for lessons, and in 1998 Erinn won the women's foil title at the U.S. National Fencing Championship. This year, Keeth is the top-ranked American fencer in sabre. In September, they will represent the United States at the 2000 Olympic Games, in Sydney.

For most of its history, fencing has had an elite, whites-only following. The Smarts took up their weapons because of an earlier African-American trailblazer, Peter Westbrook, who started fencing at a Catholic boys' school in Newark in 1967 and went on to become a thirteen-time national champion and a six-time Olympian. Today, Westbrook runs a foundation that has introduced hundreds of inner-city kids to the sport, including the Smarts and their Olympic teammate Akhnaten Spencer-El.

Fencing demands tremendous stamina and agility, both physically and mentally, and Westbrook views it not as an end in itself but as one step toward a larger education. Even if the Smarts triumph in Sydney, they won't stick around to celebrate; academic obligations will bring them home before the closing ceremonies—Keeth to finish his senior year at St. John's University, in Queens, and Erinn to complete her junior year at Barnard. "I'd like to be there, of course," Erinn says. "But we can watch it on TV."

—Ben Greenman



"Oh, by the way, your three-o'clock got squashed."

out the next two days, he and four clinicians separately interviewed each of the doctors. They were made to tell their stories over and over again, half a dozen times or more, in order to break through their evasions and natural defensiveness, and to bring out the details. Before they arrived, Neff had put together a thick dossier on each of them. And during the week he called their colleagues to sort through contradictions and ambiguities.

Neff's patients also underwent a full exam, including blood work, to make sure that no physical illness could account for any dangerous behavior. (One doctor, who was sent to Neff after several episodes of freezing in place in mid-operation, was found to have advanced Parkinson's disease.) They were given drug testing. And they underwent psychological tests for everything from gambling addiction to paranoid schizophrenia.

On the last day, Neff assembled his team around a conference table in a drab little room to make their determinations. Meanwhile, the physicians waited in their rooms. The staff members spent about an hour reviewing the data in each case. Then, as a team, they made three separate decisions. First, they arrived at a diagnosis. Most doctors turned out to have a psychiatric ill-

ness—depression, bipolar disorder, drug or alcohol addiction, even outright psychosis. Almost without exception, the condition had never been diagnosed or treated. Others were simply struggling with stress, divorce, grief, illness, or the like. Next, the team decided whether the doctor was fit to return to practice. Neff showed me a typical report: "Due to his alcoholism, Dr. X cannot practice with reasonable skill and safety at this time." The judgment was always clear, unequivocal. Last, they spelled out specific recommendations for the doctor to follow. For some doctors deemed fit to return to practice, they recommended certain precautions: ongoing random drug testing, formal monitoring by designated colleagues, special restrictions on the doctor's practice. For those found unfit, Neff and his team typically specified a minimum period of time away from their practice, a detailed course of treatment, and explicit procedures for reevaluation. At the end of the deliberations, they met with each doctor in Neff's office and described the final report that would be sent to his hospital or clinic. "People are usually surprised," Neff told me. "Ninety per cent find our recommendations more stringent than what they were expecting."

Neff reminded me more than once

that his program provided only recommendations. But once he put his recommendations down on paper it was hard for hospitals and medical groups not to follow through and hold doctors to the plan. The virtue of Neff's approach was that once trouble occurred everything unfolded almost automatically: Minneapolis, evaluation, diagnosis, a plan. Colleagues no longer had to play judge and jury. And the troubled doctors got help. Neff and his team saved hundreds of careers from destruction—and possibly thousands of patients from harm.

Despite all Neff has accomplished, however, his program was shuttered within a few months of my visit. Although it had attracted wide interest across the country and had grown rapidly, the Professional Assessment Program had never quite paid its own way. In the end, Neff was unable to persuade Abbott Northwestern Hospital to continue to subsidize it. He is hoping to set up elsewhere.

But whether or not Neff succeeds, he has shown what can be done. A few similar programs have appeared in other cities. And on April 1st the Federation of State Medical Boards, together with the National Board of Medical Examiners, opened the Institute for Physician Evaluation, in Aurora, Colorado, the first of what the organizations hope will be a national network of assessment programs. The hard question—for doctors, and, even more, for their patients—is whether we can accept such an approach. A program like Neff's cuts a straightforward deal—maybe too straightforward. Physicians will turn in problematic colleagues—the ordinary, everyday bad doctors—only as long as the consequence is closer to diagnosis and treatment than to arrest and prosecution. And this requires that people be ready to view such doctors not as sociopaths but merely as flawed human beings. Neff's philosophy is, as he put it, "hard on behavior but soft on the person." People may actually prefer the world of don't ask, don't tell. Just ask yourself, could you abide by a system that rehabilitated drug-addicted anesthesiologists, cardiac surgeons with manic psychosis, or pediatricians with a thing for little girls if it meant catching more of

them? Or, to put it another way, would you ever be ready to see Hank Goodman operate again?

Hank Goodman's life, and perhaps his career, was one of Kent Neff's saves. In mid-December of 1995, after pondering suicide, Goodman called Neff at his office. Goodman's lawyer had heard about the program and given him the number. Neff told him to come right away. Goodman made the trip the next day. They met for an hour, and at the end of the meeting Goodman remembers feeling that he could breathe again. Neff was direct and collegial and said that he could help him, that his life wasn't over. Goodman believed him.

He checked into the program the next week, paying for it himself. It was a difficult, at times confrontational, four days. He wasn't ready to admit all that he had done or to accept all that the members of Neff's team had found. The primary diagnosis was long-standing depression. Their conclusion was characteristically blunt: the doctor, they wrote, "is unable to practice safely now because of his major depression and will be unable to practice for an indefinite period of time." With adequate and prolonged treatment, the report said, "we would expect that he has the potential for a full return to practice." But the particular diagnostic labels they gave him are probably less important than the intervention itself: the act of telling him, with institutional authority, that something was wrong with him, that he must not practice, and that he might be able to do so again one day.

At Neff's suggestion, Goodman spent almost six months in psychiatric hospitals. After that, a local psychiatrist and a supervising medical doctor were lined up to monitor him at home. He was put on Prozac, and then Effexor. He stuck with the program. "The first year, I didn't care if I lived or died," he told me. "The second year, I wanted to live but I didn't want to go to work. The third year, I wanted to go back to work." Eventually, his local psychiatrist, his internist, and Neff all agreed that he was ready. Largely on their advice, Goodman's state medical board is allowing him to return to practice, although with restrictions. At first, he can work no more than twenty hours a week and only under supervision. He must see his psychiatrist and his

medical doctor on a regular schedule. He cannot operate for at least six months after returning to the clinic. Then he would be able to operate only as an assistant until a reevaluation determined that he could resume full privileges. He would also have to submit to random drug and alcohol tests.

But what practice will take him? His former partners wouldn't. "Too much baggage," he told me. He came very close to securing a place in the rural lake town where he has a vacation home. It has a small hospital, visited by forty-five thousand people during the summer months, and no orthopedic surgeon. The doctors there were aware of his previous problems, but, having searched for an orthopedist for years, they approved his arrival. Still, it took almost a year for him to obtain malpractice insurance. And he is now nervous about returning to the stresses of a full-fledged practice. He's decided to start off by doing physical examinations for an insurance company.

I recently visited Goodman at his home, a modest brick ranch-style house full of dogs and cats and birds, tchotchkes in the living room, and, in a corner of the kitchen, a computer and a library of orthopedic journals and texts on CD-ROMs. He was dressed in a polo shirt and khakis, and he seemed loose, unhurried, almost indolent. Except for the time he spent with his family, and on catching up on his field, he had little to occupy himself. His lifestyle could not be further from

that of a surgeon. I tried to picture him in surgeon's greens again—in an O.R., with another patient on the phone with an infected knee. Who could say how it would go?

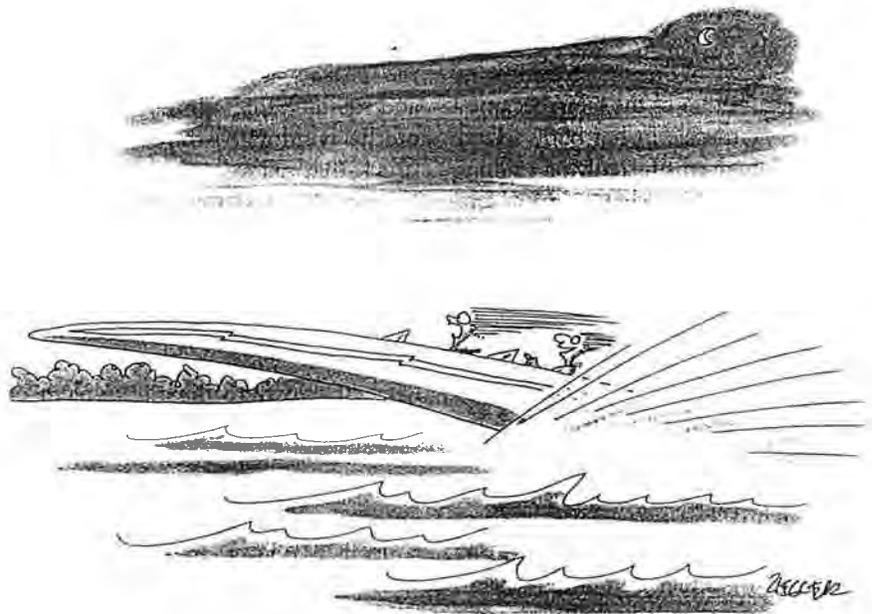
We had a meal together in town, and then drove around. Coming upon his former hospital, gleaming and modern, I asked him if I could have a look around. He didn't have to come, I said. He had not been inside the building more than two or three times in the previous four years. After a momentary hesitation, he decided to join me. We walked in through the sliding automatic doors and down a polished white hallway. A sunny voice rang out, and I could see that he regretted having come in.

"Why, Dr. Goodman!" a smiling, matronly, white-haired woman said from behind the information desk. "I haven't seen you in years. Where have you been?"

Goodman stopped short. He opened his mouth to answer, but for a long moment nothing came out. "I retired," he said finally.

She tilted her head, obviously puzzled: Goodman looked robust and twenty years younger than she was. Then I saw her eyes sharpen as she began to catch on. "Well, I hope you're enjoying it," she said, recovering nicely.

He made an uncomfortable remark about all the fishing he was getting to do. We began to walk away. Then he stopped and spoke to her again. "I'll be back, though," he said. ♦



"How's this for a romantic moonlit interlude?"

ENHANCING PHYSICIAN PERFORMANCE

Advanced Principles of Medical Management

Edited by
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CHAPTER 4

Understanding and Managing Physicians with Disruptive Behavior

BY KENT E. NEFF, MD

INTRODUCTION

Overview

Early identification of and intervention with the physician with disruptive behavior create more constructive options. Yet the common practice is to do “too little, too late” and to become involved in an adversarial process. Clarity of communication is essential, but there is often confusion about what the problem is. Physicians with disruptive behavior often complain, correctly, that no one really told them how serious the problem was until they were threatened with suspension. Knowledge of consequences is more important in determining behavior than knowledge of antecedents. But usually much more energy is spent trying to figure out why the physician does what he or she does rather than in devising appropriate consequences for the problem behavior. Finally, most physicians can hear feedback about their behavior when it is presented in a respectful manner by concerned colleagues, but this is not usually how it is done. Why is this so?

Disruptive behavior in physicians is not a new problem, but only recently has it received significant attention. Many factors are involved, including a shift in how professionals such as physicians are viewed, increasing empowerment of employees, and new laws covering sexual harassment/hostile work environments. Whereas inappropriate behavior from physicians historically was ignored or excused, such “enabling” behavior by colleagues and health care executives now carries markedly increased risk. In the current environment, failing to deal effectively with such behavior can result in significant losses of productivity and money.

There has been a tendency to excuse disruptive behavior when the physician is seen as clinically competent. Politically powerful physicians, high producers, physicians who respond with anger or launch a counterattack, and clinical “stars” in particular have avoided confrontation about their behavior. The attitudes and experience of physician leaders and the culture in which the problematic behavior occurs are important factors

affecting whether or not disruptive behavior will be addressed. In the past, the negative consequences of taking no action regarding this behavior were often minimal for the medical staff, the hospital, and the physician. In today's complex and volatile health care environment, that is no longer the case. Omnipresent pressures for increased productivity and collaborative working relationships and concerns about a hostile working environment/sexual harassment have made it imperative that all physicians be confronted about behavior that is considered disruptive.

Intervening with these physicians is not easy. More often than not, executives and managers still tend to look the other way until the problems become urgent. We do "too little, too late." By the time an intervention is done, everyone is upset with the physician, and the situation has become adversarial. Effective communication has stopped, and people have chosen sides. Options have become more limited, and the chances of a positive outcome have been reduced. The medical director or administrator can become an unwitting lightning rod for frustrations that should be directed elsewhere. Trust suffers, and it becomes more difficult to work collaboratively. Experience has now shown that these difficult issues can be addressed constructively, resulting in a "gain-gain" outcome in many cases. The framework, strategies, and methods for doing so are the topics of this chapter.

Definition of Disruptive Behavior

The following definition is a good starting point: "An aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care."¹

In essence, any behavior that could reasonably interfere with patient care, communication, morale, the functioning of the health care team, etc. could be considered disruptive. This could include language; personal habits, such as cleanliness; manner; or style.

Examples of disruptive behavior may include:

- Profane or disrespectful language
- Demeaning behavior, i.e., referring to hospital staff as "stupid"
- Sexual comments or innuendo
- Inappropriate touching, sexual or otherwise
- Racial or ethnically oriented jokes
- Outbursts of anger
- Throwing instruments or charts
- Criticizing hospital staff in front of patients or other staff
- Negative comments about another physician's care
- Boundary violations with staff or patients
- Comments that undermine a patient's trust in a physician or the hospital

- Inappropriate chart notes, e.g., criticizing a patient's hospital treatment
- Unethical or dishonest behavior
- Difficulty in working collaboratively with others
- Failure to respond to repeated calls
- Inappropriate arguments with patients, families
- Poor response to corrective action

Legal Considerations

Concerns about legal action are often cited as reasons not to take action in a case of disruptive behavior. However, greater liability occurs by not taking action rather than by taking appropriate disciplinary action, as long as it is done in the correct manner.² Documentation is critically important. There is well-established support in case law for dealing firmly and decisively with physicians whose behavior is disruptive.²

Obviously, involving legal counsel at appropriate points in the process of managing these physicians is necessary and prudent. However, responding in a formal, legalistic manner is very threatening to physicians and may create an unnecessary adversarial relationship. The physician is likely to respond defensively, often through his or her own attorney. Meaningful dialogue is blocked. There are often more constructive ways to get the physician's attention early in the process.

An appropriate balance needs to be struck. If the actions of the medical director are based only on legal concerns, some constructive options may be missed. Animosity, polarization, and a poor outcome are more likely to result when this occurs. Establishing and maintaining respectful dialogue, attempting to work collaboratively with the physician, and avoiding formal adversarial actions as long as there are other reasonable options available are strongly recommended. Experience shows that much can be done before it is necessary to invoke a formal adversarial process. Establishing and maintaining a dialogue-based process as long as possible can avoid many pitfalls.

The Importance of Addressing Disruptive Behavior

Disruptive behavior must be addressed promptly for two reasons. The first is that the behavior itself can adversely affect patient care, either directly or indirectly. The behavior may put the patient at risk or lead to a poor outcome. Such behavior can directly affect the members of the health care team and their ability to work collaboratively. This behavior also may increase the risk of malpractice and of harassment claims and litigation.

The second reason is that disruptive behavior may be a sign of an illness or a condition that might affect clinical performance. Disruptive behavior and clinical performance problems may share the same roots. The first or the only sign that a physician's clinical performance may be at risk may be an episode of disruptive behavior. Given the autonomous nature of medical practice, such observable behavioral signs occur only infrequently and must be investigated. The following example is illustrative:

A dedicated but demanding young surgeon who was a superb clinician was noted to be increasingly irritable in the operating room during difficult cases. This behavior began to escalate, and he had several outbursts of verbally abusive behavior toward nurses. One day, during a period of great frustration, he struck a nurse.

The incident was immediately reported to the Vice President for Medical Affairs. After a prompt investigation, the physician was suspended and sent for assessment. He was found to be under extraordinary personal stress and to be quite depressed. In addition, serious unresolved developmental issues from his childhood were identified. At a clinical level, he was considered not safe to practice until his depression had been adequately treated. The physician was most cooperative and was relieved to receive some help. A brief medical leave of absence, antidepressants, and psychotherapy were recommended and agreed to by the physician. Colleagues and the hospital were very supportive. His prognosis was considered excellent.

His clinical performance remained intact throughout this period. But the assessment demonstrated that his clinical performance was at great risk. It is likely that his problems might never have been discovered had the behavior not been identified as disruptive and an intervention done promptly. A more serious problem may well have been averted by prompt, decisive, corrective action.

Disruptive behavior should be reframed as a serious liability and patient safety issue. Intervention should be considered an opportunity to help a physician in personal difficulty, ideally before his clinical performance is at risk. Taking this view facilitates more appropriate responses, and the task becomes less onerous.

Managing the Problem Versus Responding to Crises

What generally resulted from this historical *laissez-faire* approach was an unorganized, case-by-case “crisis” method of dealing with problems. There was no systematized, written, proactive approach designed to minimize liability and increase the chances for a positive outcome. While sometimes a good formal process was spelled out in the medical staff bylaws, carefully crafted procedures for identifying, intervening with, evaluating, supporting, and monitoring these physicians were usually missing. Barriers to setting up such procedures included a lack of appreciation of the extent and importance of the problem, a sense that “it could not happen here in our fine institution or with our excellent physicians,” wanting to avoid a “witch hunt,” concern about legal liability, and not knowing how to proceed.

All medical organizations, regardless of size or type, should expect these problems to occur and should plan for them in advance by establishing good procedures. The failure to do so only increases potential liability for the institution and the likelihood of losing valuable physician resources.

Reframing the Behavior and Taking a Positive Approach

Effective management of physicians with disruptive behavior is an art born of common sense, compassion, respect, and good planning. These difficult issues can be viewed as a problem or as an opportunity. It is best to take a positive, proactive stance rather than approaching it from a negative, confrontational point of view. Emphasize the positive side, promoting respect and harmony in the workplace. Managing physician behavior is a process, not an event. It starts with dialogue, building trust, and placing emphasis on the problem behavior, not the person. Consider the following example:

An internist in his 50s, upset over an adverse action of the Peer Review Committee, became verbally abusive and disruptive at a medical staff meeting. A highly productive and competent physician, he had become increasingly uncooperative in the hospital's effort to partner with physicians. The hospital CEO and medical staff president were spending considerable time fielding numerous written complaints from this physician. Concerned about what to do, the hospital administrator retained a consultant.

The physician in question was found to be dedicated to good patient care and highly concerned about his patients. His style was rigid and uncompromising, and he had limited interpersonal skills. He was having great difficulty in adjusting to recent changes in the health care environment and was becoming increasingly disenchant-ed and isolated. A leader in the hospital, he felt that he was no longer appreciated.

The consultant recommended to the administrator that he meet regularly with the physician and attempt to reestablish a relationship and to build trust. Long frustrated with this physician's behavior, he was initially quite resistant to this suggestion. But he did begin to meet with him for lunch regularly. There was a subsequent reduction in the doctor's disruptive behavior. While problems with this physician were far from resolved, the stage was set for more productive communication and interaction with him.

Instances of disruptive behavior are grossly underreported. The frequency and the severity of such events are much greater than is generally appreciated. An effective strategy for addressing disruptive behavior must create an environment in which early reporting is encouraged and supported. The threshold for tolerance of inappropriate, disrespectful behavior must be lowered. These changes can best be accomplished through positive, reasonable, nonpunitive means. Collaboration by many different professionals in the organization is necessary. A punitive attitude or response toward either the person reporting the incident or the physician will sabotage efforts to address this problem more constructively.

The Credentialing Fallacy¹

A second shift involves moving from a static concept of fitness for practice to a dynamic model that takes into account changes over time. Traditionally, it was considered that, once a physician was appropriately credentialed, he or she was safe to practice.

This was eventually referred to as the “credentialing fallacy.”¹ In essence, physicians were divided into two camps: good doctors and marginal doctors. Inadequate attention was paid to the fact that any physician, even a highly competent one, could be adversely affected by many factors, resulting in substandard clinical performance. In essence, *any* physician, given the right circumstances, has the potential to become impaired in his or her practice. Neither competence nor good intentions fully protect a physician from this possibility.

The new approach involves tracking more than just competence. The bottom line is not just what the physician knows, but what he or she does with patients, i.e., his or her clinical performance. Ensuring safety to practice is a dynamic process that is affected by behavioral, emotional, and physical factors. Clinical performance should be periodically reassessed, particularly if signs of problems arise. In the case of both disruptive behavior and clinical performance problems, psychological, addictive, and medical conditions may be associated and/or causative. It is usually appropriate to search for them under these circumstances. If such potentially impairing conditions are present, insisting upon treatment and documenting that there has been sufficient resolution to allow safe practice are recommended.

UNDERSTANDING THE FACTORS ASSOCIATED WITH DISRUPTIVE BEHAVIOR

The key to successfully managing physicians with disruptive behavior is to intervene in a manner that is likely to get the physician’s attention and to motivate him or her to work with you in making appropriate changes. Therefore, trying to understand how the situation is perceived by the physician is important in devising good strategies. The disruptive behavior indicates that there is a behavioral problem, but it usually gives little information about what is behind the behavior. While there is often some correlation between the severity of the disruptive behavior and the severity of the causative condition, relatively benign but still disruptive behavior may be the only sign that the physician is seriously impaired. Developing a clear understanding of common causative or contributing factors is necessary. It is also helpful to understand common personality attributes and common experiences of physicians, as these have implications for how to intervene effectively.

The Current Health Care Environment

The current volatile, “pressure-cooker” health care environment is extremely stressful for physicians. It is perceived as highly threatening. Physicians are losing their much-valued autonomy. They are working harder and making less. Practicing medicine is not nearly as satisfying as previously for many physicians. At times, the medical environment can be demeaning and/or downright abusive to physicians. This threatens the already fragile self-esteem of many physicians. Anxiety is increasing. There is a sense that they have sustained many professional losses in the past few years. Many physicians feel a sense of powerlessness and confusion and are overwhelmed by the current realities in medicine.

This is important to understand. The unique characteristics of today's health care industry are especially difficult for physicians to accept and manage. They often lack the basic personal, interpersonal, and organizational skills to cope effectively with these new realities. Their fears and apprehensions are reality-based.

Acknowledging to the physician with disruptive behavior that you appreciate the harsh, unforgiving nature of the current health care environment is often helpful. But it is important to continue to insist that the physician change his or her responses to these stressors, i.e., his or her behavior, despite the perceived unfairness of it all.

Organizational Issues

The organizational culture determines the extent to which disruptive behavior will be identified as a problem and how it will be managed. Most health care organizations' cultures, regardless of type or size, present problems in this area. For example, there is usually a lack of adequate accountability for physician behavior. Problem behavior is frequently ignored until it escalates and becomes chronic, leaving fewer nonadversarial options for the medical executive. The threshold for tolerance of disruptive behavior is usually much too high. Left unaddressed, disruptive behavior often spreads to other colleagues and staff. The following example of a health care system with two hospitals and a conjoint medical staff is illustrative:

One of the two hospitals had a serious and escalating problem with a variety of disruptive behaviors by physicians in operating rooms. Both anesthesiologists and surgeons were involved. The problem became so severe that a consultant was engaged to assist in managing it.

The behavior of several physicians was identified as particularly egregious. Two physicians were identified as having such serious clinical performance deficiencies as to be considered impaired; possible impairment was noted in a third physician. Two of the physicians were promptly suspended by the medical staff on the basis of their clinical performance problems. There was a noticeable reduction in the level of disruptive behavior by other physicians after these actions were taken.

The behavior of several other physicians was also determined to be disruptive, but no formal standard for behavior existed. Because of concerns that taking action without an objective standard in place would be perceived as autocratic by the medical staff, it was decided to develop the standard first, before taking any further action. The Principles of Partnership (Appendix 1, page 66) was used as the initial draft and was approved by both the medical staff and hospital administration. Once this document was in place, a program for managing the disruptive behavior was implemented successfully.

The second hospital, located in the same city, did not have problems of similar severity in its operating rooms, despite the fact that the two hospitals had conjoint medical staffs.

A final point is that the initial phases of introducing more accountability for physician behavior are the most difficult. Once appropriate limits have been successfully set with a physician or two, it gets easier. This is particularly true when the approach is supportive and constructive as well as firm.

Personal Factors Common to Physicians

Physicians as a group tend to be quite autonomous, a characteristic often cited as an important reason for choosing medicine as a profession. They tend to be highly inner-directed and are sensitive when criticized. Their high intelligence can complicate matters by helping them develop effective defenses against changing their behavior. Many are perfectionistic and detail oriented, often having difficulty seeing the bigger picture. Because they see their intentions as good, they are offended when someone suggests otherwise by criticizing their behavior. Physicians have such a strong bond to their profession, and so much of their affirmation is obtained through their work, that professional criticism of any kind may result in feelings of devastation. Physicians often perceive not only that they have done something wrong, but also that they are bad doctors or bad persons. They may become overly defensive, making it difficult to work with them. In professional liability litigation cases, these factors may contribute to physicians' feeling so devastated that they cannot ably assist in their own defense.

Medical Education and Training

The hard work and delayed gratification necessary to gain admission to medical school often mean that the entering medical student may be less socially experienced than his or her nonmedical peers. Regardless, medical school is a powerfully influential experience. Technical considerations take precedence over interpersonal ones. The physician is trained to seek perfection. The belief that he or she cannot make a mistake, that "good" physicians do not make mistakes, creates barriers to self-examination. If the physician comes from an abusive background or one in which self-affirmation came primarily from high achievement, there may be a synergistic effect.

In addition, medical school and residency may negatively affect self-esteem. At times the two environments can be downright abusive, again being synergistic with vulnerable physicians. Faculty may provide distant, impersonal, negative models in terms of doctor-patient interaction and treatment of nurses and staff. It is not surprising that the practicing physician, when under stress, may exhibit similar demeaning and abusive behavior. The following example is illustrative:

A gifted internist in his 40s became increasingly irritable and argumentative with clinic staff. Very demanding of himself and others, and a perfectionist, he began to have outbursts of verbally abusive behavior toward staff when he was under stress. This escalated to the point that he had several verbal altercations of a similar nature with several patients. An intervention was done, and he was referred for a comprehensive assessment.

He did not have a psychiatric disorder, but he did come from an abusive family. This pattern of abuse continued in medical school and residency. He could remember times when he had been verbally abused and even physically assaulted in residency. Despite his impeccable clinical performance, he had poor self-esteem and low self-confidence. He responded well to outpatient psychotherapy and training in communication skills. Follow-up for several years yielded no further recurrences of the disruptive behavior.

Developmental Issues

Unresolved developmental issues are frequently associated with physicians whose behavior becomes disruptive.³ Childhoods characterized by neglect and/or abuse are common in these physicians.³ Often the harshness of the past was not recognized by the physician.³ Sometimes the past trauma has been so overwhelming that it resulted in post-traumatic stress disorder.³ These emotional scars may contribute to a wide variety of clinical psychiatric disorders, problematic personality traits, personality disorders, or future behavioral difficulties unaccompanied by a psychiatric diagnosis. Low self-confidence and self-esteem often result. Intellectually gifted, many future physicians find affirmation in academic or other accomplishments, but languish in their emotional development. Medical school and training only exacerbate these problems. This sets the stage for future difficulties in interpersonal relationships and communication under stress. The present harsh environment in medicine may be particularly difficult for these physicians. Not infrequently, there is a clear connection between the nature of the childhood experience and behavioral problems in practice. Consider the following example:

An excellent internist in her 30s was rude and demeaning to both nurses and patients. The problem was worse in the emergency department, where she was quite resistant to seeing certain kinds of patients, especially those who were not particularly ill at the time of their visit. She avoided ED call whenever possible. Her partners in the medical group intervened and referred her for assessment as a condition of remaining in the group.

She did not have a clinical psychiatric disorder, but the roots of her behavioral problems could be traced directly to her experience in her family of origin. Her father was a medical practitioner and was the dominant presence in the family. Expectations were very high, and the physician and her siblings were expected to carry on despite illness or adversity. One was not considered "ill" unless essentially bedridden. The physician had internalized this family attitude toward illness, developing a pejorative attitude toward the "worried well."

The physician began outpatient psychotherapy and did well. Her practice partners made some adjustments in her ED call schedule to reduce her exposure there for a time. In return, she took call on another service. The rude, abusive behavior stopped.

Psychiatric Disorders

A wide variety of psychiatric disorders are commonly associated with physicians whose behavior becomes disruptive.³ The disorders may be causative or contributory. The most common disorder seen in this group of physicians is major depressive disorder. Alcohol and drug dependence are also seen frequently, as would be expected. Bipolar disorder is surprisingly common and may be so severe as to produce impairment in practice. Other psychiatric illnesses, such as obsessive compulsive disorder, may also occur in this group of physicians. The number of accumulated losses, both personal and professional, may be significant and is commonly ignored by the physician and his or her colleagues. Unresolved grief is frequently a contributing factor to the physician's problems. Doctors in certain specialties, such as oncology, experience numerous losses in conjunction with their practices and are particularly prone to "burnout."

Personality disorders may also be present (less than a third of cases).³ When present, they may be a very important contributor to the pattern of disruptive behavior. These are usually compatible with continued practice once the physician is able to change his or her problem behavior. Prominent personality traits that are not so severe as to reach the level of a disorder are common and are also major contributors to disruptive behavior patterns. With timely intervention, treatment of any underlying conditions, good follow-up, and monitoring, it appears that most of these physicians can be safely returned to practice. In many cases, even partial resolution is sufficient to allow return to practice,³ as long as there are no current concerns about patient safety and there is appropriate monitoring.

Physical Illness

Physical illness is generally overlooked as a cause of or contributing factor to disruptive behavior in physicians. It is often minimized or ignored by both the physician and his or her colleagues. Physicians with disruptive behavior frequently have not had regular medical examinations.³ Many physical illnesses can lead to actual impairment in practice if left unchecked. The possibility that the physician is simply a sick physician should always be kept in mind. A medical history and physical examination should be part of any comprehensive assessment of a physician with disruptive behavior. Evaluating physicians should be informed about the full scope of the doctor's behavioral problems, as well as any other concerns of the referent.

Examples of physical illnesses that have been associated with disruptive behavior are sleep disorders, multiple sclerosis, diabetes mellitus, and Parkinson's disease.³ The relationship of these disorders and other medical illnesses to disruptive behavior may be direct, as in cognitive problems directly caused by the illness, or indirect, as in a physician recently diagnosed with Parkinson's disease who was unable to perform his medical duties because of fatigue and preoccupation with his diagnosis and its potential catastrophic effect on his life.

Litigation Stress

Dr. Sara Charles, in her groundbreaking work on litigation stress in physicians, identified

a number of serious sequelae to the professional liability litigation process, including significant anger, depression, and physical illness.⁴ These and other consequences of professional liability claims can affect a physician's behavior to the point that it becomes disruptive or the physician becomes impaired in his or her practice. A number of approaches have been used in attempts to mitigate the stress of this common occurrence, with varying results. Litigation stress and its consequences continue to be a significant problem. It is all too frequently minimized by the sued physician and colleagues. Litigation stress should always be considered a potential contributor to disruptive behavior. If present, it needs to be directly addressed in a supportive, collegial manner, concurrent with efforts directed at changing disruptive behavior.

ESTABLISHING A FORMAL BEHAVIORAL STANDARD

Most health care organizations have carefully articulated mission statements. In contrast, very few have written behavioral standards, particularly ones that apply to physicians. This creates significant problems when a suspected case of disruptive behavior arises. With no preexisting standard, the initial determination of whether the behavior is truly disruptive becomes much more difficult. Also, the lack of a formal standard makes it more likely that there will be inconsistencies in the type and severity of behavior that is considered disruptive.

Establishing a clear, reasonable, fair, and firm behavioral standard is the first step toward long-term success in managing disruptive behavior in physicians. The process of drafting and approving such a standard can be a good opportunity for educating the medical staff and others about the importance of respectful behavior. An open process of discussion allows concerns and fears of physicians to surface and be allayed. Most physicians will support a document they consider reasonable and fair. Medical staff approval should not be difficult. *The Principles of Partnership* (see Appendix 1, page 66) has been used as the starting draft in numerous hospitals/ health care organizations. Each medical staff can make appropriate modifications as it sees fit. Some medical staffs have incorporated the *Principles* into their bylaws; others have required that the behavioral standard be signed at initial credentialing and whenever privileges are renewed.

An ideal approach is to have the medical group or other health care organization develop a parallel *Principles* for its employees, resulting in the same standard for everyone. At the very least, behavioral standards for physicians and other employees should be very similar and compatible. Physicians are not the only professional group to present with disruptive behavior. For example, nurses may also exhibit such behavior.

GUIDING PRINCIPLES FOR MANAGING PHYSICIANS WITH DISRUPTIVE BEHAVIOR

Successful management of physicians with disruptive behavior is a collaborative task. While the actual intervention with the physician usually falls on the shoulders of the physician executive or the administrator, many people from different disciplines may contribute to the process. Physicians are not at all the most important source of information in most

cases. Nurses, office staff, department managers, and others who work closely with the physician or under the physician's direction usually are much better reservoirs of useful information. These professionals must be included in the process. Doing so involves risk on both sides. Establishing mutual trust is a prerequisite for this process to work.

While physicians cannot manage these colleagues without involvement from other groups, physicians are almost always the most effective intervenors with their colleagues. The physician-to-physician approach is usually much better received by the physician being confronted. Responsibility for management of physicians with disruptive behavior should be assumed by physicians whenever possible. Of course, this should involve close collaboration with administration and/or the board of directors as appropriate. Because division of responsibilities varies in organizations, delegation of this responsibility may parallel established organizational policies and procedures. Physicians should be the primary intervenors, but involvement of a member of the administrative team or board may be prudent under some circumstances. The timing of such involvement may be critical. The unique aspects of each situation should dictate these decisions. Involving family members often carries great risks, because unknown, problematic dynamics may take precedence and sabotage intervention efforts. Both spouses and practice partners may have difficulty maintaining confidentiality, also a serious problem. It is usually better to avoid these potential problems and not involve family in the intervention. Close personal associates of the physician should not be involved if, for any reason, there is concern about their behavior in the planned intervention process.

Managing these physicians is not an event; it is a *process*, akin to the difference between managing acute and chronic illness. Different principles are involved. This process will be more effective when it involves careful planning and thoughtful, ongoing dialogue rather than being simply a response to crises as they occur. The following guiding principles may be useful:

Respectful and Safe for All Concerned

Disruptive behavior is usually disrespectful behavior. Effective management involves ensuring that this behavior stops while more respectful behavior from everyone is proactively encouraged. Practicing respectful behavior at all times engenders trust and collaboration and models proper behavior. The physician in question, whose self-esteem is usually low, will respond much more positively if approached in a dignified, respectful manner. Nurses and others who might be involved at some point in the process should also be treated with great respect. Being respectful does not imply weakness or lack of resolve.

Being respectful includes extending common courtesies and using appropriate social skills. Judgmental or emotionally charged words should be avoided. Care should be taken to separate objective data from opinions.

Confidential at All Stages

Maintaining confidentiality in hospitals and medical groups is usually a difficult task. But keeping everything in this process fully confidential at all stages is absolutely essential for success. Leaks of information not only potentially sabotage intervention and resolution processes, but also create considerable legal and economic liability potential. It is nearly impossible to create trust in a process that is not confidential.

Maintaining full confidentiality also allows one to work informally in the organization and get reports of problem behavior earlier. In many cases, no one will come forward unless there are assurances that the source will be kept confidential. These requests should be honored. The physician executive doing the intervention should be fully convinced that the behavior is documented and inappropriate. This personal conviction and the objective data should be communicated to the physician, taking the focus off any specific individual who might have written an incident report. Experience shows that it is not necessary to reveal the original source of such information.

Timely and Prompt

Timeliness of investigation and intervention is critical to maximize the chances of a successful outcome. Just as in certain medical situations, there is a “golden period” for intervention that helps ensure a good result. Often, the physician knows that he or she was out of line and feels bad after a disruptive episode. Right after the event, the physician may be able to recognize the problem and be more amenable to doing something about it. Prompt attention to the matter is also reassuring to staff, who often wonder whether or not the medical staff will even address the problem. In cases in which a proper investigation cannot be completed quickly enough, a meeting with the physician to inform him or her that you are aware of the incident, are looking into it, and will meet with him or her later may tip the scales in your favor and make a subsequent intervention easier.

Planned Carefully and Managed at Every Stage

Every action taken should fit into a carefully crafted plan. Actions contemplated should be examined beforehand for their potential effects and consequences. Meetings and interventions should be orchestrated as much as possible. Specific tasks should be assigned, e.g., who should say what and when. Intervention meetings need to be rehearsed in advance. Set a list of potential goals and acceptable outcomes for the meeting. Plan for certain contingencies that may arise. Set dates or deadlines for certain phases of the process when appropriate. Keep the process moving along. Significant delays usually work against you.

Fair and Supportive in Orientation

Fairness and a genuine willingness to assist the physician to correct the problem are also essential elements of a successful process. Maintaining this attitude may be especially difficult when the physician’s behavior is egregious or the physician has failed

to change despite repeated admonishment. Experience shows that these physicians can and do change their behavior when approached and when appropriate help is given.³ Colleagues and hospital staff members will accept and even support firm action if they see that the physician is being treated fairly and is being given a reasonable chance to change.

Based on Objective Data Presented in Nonjudgmental Terms

Information about disruptive incidents is often subjective and judgmental. When this is the case, making accurate assessments of the problem and good judgments about potential actions may be very difficult. Presenting the problem behavior to the doctor in this form is likely only to antagonize him or her and thwart effective communication. The problem behavior should be carefully described in *objective, observable, nonjudgmental* terms. Specific times, dates, and details should be included when possible. The quality of the subsequent intervention can be only as good as the quality of the data. Presentation of objective, detailed data, free of impugned motives, offers leverage in influencing the physician to change. Well-documented, objective data also may protect you from liability at a later time.

“Hard” on the Problem Behavior, “Soft” on the Physician

This concept is taken from mediation theory and is the *sine qua non* of a successful intervention.⁵ In other words, *separate the physician from the problem behavior*. The *behavior*, not the doctor, is the problem. That is why the term “physician with disruptive behavior” is preferable to “disruptive physician.”

Most physicians with disruptive behavior have good intentions. It is always necessary to acknowledge *the physician’s value at the beginning of the meeting*. Give specifics about what it is about him or her that is good and appreciated. The message should be: “You are a good and valued physician. It is your behavior that is the problem.” Such statements, delivered in a respectful manner by meaningful colleagues, maximize the chance that the physician will be able to hear your concerns about his or her behavior. Failure to emphasize up front that the physician has value, especially given the personality profiles of physicians with disruptive behavior, is likely to have disastrous consequences for communication with that physician.

Incremental, with Graded Responses and Consequences Appropriate to the Situation

The ideal process is incremental, with the physician executive making graded responses appropriate to the severity of the behavior, to whether it is the first infraction or a repetitive problem, to the potential consequences to patient care, to the extent of potential legal liability, and so on. Responding in this manner is often difficult, because reporting is late and the intervention is done when the situation has escalated into a crisis. Earlier reporting and prompt investigation increase the opportunity for appropriate, graded actions. Some physicians will respond well to a clear statement of concern by colleagues.

Knowledge of consequences is more important in influencing behavior than knowledge of antecedents. Clear consequences for behaving inappropriately are often lacking. In these situations, the physician has little incentive to change. Adding appropriate consequences—again, matching the severity of the potential disruption—gives the physician some incentive and the physician executive some leverage. A common example of this phenomenon occurs around medical records. Some physicians will simply not complete their charts until they are threatened with suspension. A smaller number will do nothing until they actually are suspended. Some, of course, won't complete them under almost any circumstances. When this happens, the primary focus should shift to examining the past behavior of the medical staff and organization in terms of what the real consequences of noncompliance have been, how consistently they have been applied, and whether there really is a willingness to set firm limits and enforce them. The disruptive physician will often readily sense whether or not his colleagues are serious about the matter at hand. A small but important subset will do nothing meaningful until they are convinced they have to. Such self-examination should always be part of the process when the medical staff, for example, begins to get tougher about disruptive behavior by physicians.

Kept “Informal” and Nonadversarial as Long as Possible

While the bylaws of the organization usually outline a series of actions and protect the physician through due process, the goal is to remain out of the formal bylaws process for as long as possible. The most effective process is to keep the dialogue going, maintaining an “informal” stance free of rigid legal constraints. Most problems involving disruptive behavior can be resolved at this level. If the bylaws are invoked, the battle is to some extent lost. Obviously, this escalation cannot always be avoided. By following the other principles outlined, the physician executive can increase the likelihood of a successful intervention without going through cumbersome due process.

Involve Careful, Ongoing Follow-Up and Monitoring of the Physician

Because disruptive behavior tends to be caused by chronic conditions or acute exacerbations of chronic conditions, careful follow-up and monitoring are essential. The prognosis for successful sustained change is helped by good monitoring. It reminds the doctor that he or she is being observed. Lapses in behavior may be picked up promptly and a full relapse averted. Adjustments to treatment or remediation can be made. Staff and colleagues are reassured. It protects the organization, because potential liability is reduced. Paradoxically, it can protect the physician as well by providing benchmarks indicating that he or she is doing well. Far too little attention is paid to this critical function. All physicians who need to be confronted about disruptive behavior should have some form of monitoring. The type, time frame, and nature of the monitoring and of regular feedback should be appropriate to the situation. The same rules of intervention apply: feedback should be respectful, objective, and balanced, with both positive and negative observations.

EVALUATION, MONITORING, AND FOLLOW UP

Outside Evaluation as a Resource

In order to determine whether or not the physician is safe to continue practicing, or what the likelihood is of a recurrence of the disruptive behavior, the medical executive often needs more information than is available at the time of intervention. In these cases, referring the physician for a third-party evaluation is strongly recommended. Such assessments can be very helpful, both to the referring individuals and to the physician with disruptive behavior.

An outside evaluation should usually be more than just a standard medical or psychiatric examination. Frequently what is needed is a “fitness for duty” evaluation. The experienced evaluator or evaluation team can often gain access to more information than is available to the medical executive. They are not constrained by the adversarial nature of the relationship that has often developed. The assessor should have specific expertise relevant to the problem being assessed. There may be substantial advantages to a multidisciplinary team assessment rather than a single-party evaluation, because a single evaluator, no matter how skilled, can be misled much more easily than a team. The evaluators should always receive all relevant information about the physician’s problem behavior. The credibility of an evaluation done without this information should be called into question. Inadequate or incomplete evaluations may create new problems by creating a false sense of security about the physician’s fitness to practice, or by giving the physician leverage in resisting further oversight by colleagues.

Guidelines for Evaluations

The following guidelines may be useful to consider:

- Decide what kind of evaluation is indicated.
 - ▶ Be very specific about what you want.
 - ▶ Request references from the proposed evaluators, and contact them regarding outcomes and satisfaction.
 - ▶ Select the potential evaluators according to qualifications and experience specific to the assessments you want.
 - ▶ Use evaluators with good experience in dealing with physicians whenever possible.
- Tell the physician which evaluator to consult, or let him or her select from a list of evaluators whom you consider to be qualified.
 - ▶ Do not let the physician select his or her own evaluator.
 - ▶ Disqualify any close friends or associates of the physician being evaluated.
- Use someone outside the group or organization when possible and appropriate.
- Make sure that the evaluator does not have biases against what you are doing or against your organization.

- Contact the evaluator yourself and tell him or her the purpose of the evaluation and what you expect.
 - ▶ Be very specific.
- Furnish the evaluator with *all* relevant information regarding the physician's behavior, staff observations, and other objective data.
 - ▶ Never allow the physician to be evaluated without the assessor knowing the full picture and why you are concerned.
 - ▶ Ask the evaluator to review the information before seeing the physician.
- Always request some screening for alcohol and drug problems.
 - ▶ Make sure the evaluator understands how addiction presents in physicians.
 - ▶ Request a full addiction evaluation when indicated. This usually requires a separate evaluation. Use a physician skilled in the evaluation of physicians.
- Always include a medical history and physical examination.
- Allow the evaluator to see the physician as many times as necessary to complete the evaluation. Encourage multiple evaluation visits.
 - ▶ Several encounters may give a clearer picture of the problems.
 - ▶ Request that the evaluator interview the spouse when alcohol or drug problems are suspected.
- Involve the state Physician Health Program when addiction is suspected. Some state PHPs also assist with disruptive behavior problems.

Comprehensive, Multidisciplinary Team Assessment

In recent years, comprehensive assessment by a multidisciplinary team has gained increasing acceptance as a useful resource in the armamentarium for managing physicians with disruptive behavior. These assessments usually last from two to four days—more commonly, the latter. While not necessary in all cases, these assessments may offer great advantages. Physicians are difficult to evaluate because of their high intelligence, education, skills, and position. Identification with the subject of the evaluation can also be a problem for the evaluator. Many physicians have difficulty being assertive with colleagues in these delicate relationships. Individual evaluators are often unable to influence the physician to take ownership of behavioral problems. A comprehensive team can often overcome these obstacles, empower the physician, and get him or her to see the team's perspective and take ownership of the problem behavior.

Examples of situations in which this kind of assessment should be considered include:

- Clinical performance problems
- Complex cases

- Disputed, conflicted cases, e.g., where the physician resists evaluation or denies that there is a problem
- Suspected alcoholism or other chemical dependency
- Diagnostic dilemmas
- Chronic relapsing of an addicted doctor or dual diagnosis cases
- High-stakes cases, e.g., a high producer or high-profile physician
- Politically sensitive cases, e.g., a medical staff leader
- High-liability cases, e.g., hostile work environment or threat of litigation
- Sexual harassment cases
- Cases in which licensure or hospital privileges are at risk
- Suspected cases of sexual impropriety or boundary violations
- Chronic cases of disruptive behavior unresponsive to intervention

Separation of Evaluation and Treatment

Most team assessment programs have arisen from existing addiction programs whose primary role has been to evaluate and treat addicted people. Many treatment programs have excellent assessment programs that are quite effective, particularly when the referral and the potential diagnosis are accepted by the physician. However, caution should be exercised in using this option, especially when there is initial resistance on the part of the doctor. In these cases, and perhaps in most cases, full separation of the evaluation and the treatment components is recommended. It is usually safer and less subject to criticism. If a conflict of interest on the part of the assessment team is perceived, additional liability may be created for the referent. The credibility and the impartiality of the assessment team are of paramount importance. Physicians being assessed have often commented that they feel safer and are more willing to disclose sensitive information when the assessment is completely separate from any recommended treatment.³

There have been a number of contentious lawsuits around these issues in recent years. The threat of legal action would be expected to increase if the concerns of the physician are not addressed promptly or if the physician is forced into accepting a diagnosis or treatment that is not based on unbiased, objective criteria. The referring organization and individuals could become included in these legal actions. State Physician Health Programs can be very helpful in these difficult, conflicted cases.

State Physician Health Programs (PHPs)

No discussion of this type would be complete without mentioning the important role of state Physician Health Programs. They have done pioneer work in educating, identifying, evaluating, referring, and monitoring physicians with alcoholism and drug dependency. Most states have some kind of program. The scope of available services varies considerably from state to state, as would be expected. Regardless, PHPs are an important resource for the physician executive. Their considerable experience and broader perspective regarding the management of the addicted physician improves the outcome and may also

reduce liability. A confidential referral of chemically dependent physicians to the state PHP is strongly recommended. Each medical executive should be aware of the state PHP and should know how to access and use its services.

Over the past few years, the role of many PHPs has been broadened and expanded to meet new areas of need. Disruptive behavior is now being addressed by some PHPs. Given the mission of most programs to serve physicians throughout the state, it is likely that more PHPs will offer some services for physicians with disruptive behavior.

Hospital or Group Physician Health Committees (PHCs)

An increasing number of medical groups and hospitals have established their own committees to assist in managing these physicians. In California some years ago, hospitals were mandated to establish and maintain these committees. Establishing such a committee can be very helpful and can serve as the focal point for education and physician awareness building. It is recommended that all hospitals and medical groups of more than a few physicians consider establishing a PHC.

Monitoring and Follow Up

Monitoring the progress of physicians with problem behavior has long been observed to improve the prognosis for maintaining appropriate behavior and remaining safe to practice. The monitoring process can also provide ongoing support to these physicians, as well as frequent reminders of the need to follow recommendations. For these reasons, all physicians with disruptive behavior should be monitored in some manner. The type and degree of monitoring will, of course, vary, depending on the disruptive behaviors and what is behind them. This is another reason why it is so important to understand what has been causing the behavior. In order to be most effective, both the behavior and compliance with the recommendations for treatment should be monitored. This is routinely done with alcoholic physicians, whose abstinence and active participation in a personal recovery program are both monitored by PHPs.

The lack of good monitoring is often the weakest link in the chain of management of these physicians. Monitoring is often poorly organized, too informal, not started promptly, discontinued too quickly, and done in a punitive manner. The group or hospital PHC can be very helpful in implementing a better monitoring program.

Treatment or other recommended activities should be monitored. Do not take the physician's word that things are going well. This presents a dilemma regarding confidentiality, which is necessary for most treatment to be effective. Also, the physician has a right to confidentiality in the therapy process. Two approaches may be helpful. The first is to ask any treatment provider to keep all information confidential except the physician's participation in the therapy (i.e., whether the physician is attending as requested by the therapist and is complying with the treatment, and whether the therapist considers the physician safe to practice). The second option is to use an "administrative" clinician in

addition to the treating clinician. The administrative clinician could periodically do a separate evaluation of the physician's status and progress, including making a determination as to whether the physician is safe to practice. This would constitute an independent medical examination (IME), and the full results would be reported to the physician executive. This would remove the treating clinician from any conflict of interest and fully protect confidentiality of sensitive information.

Some guidelines for monitoring are:

- Start the planning process for monitoring early.
- Explain to the physician why you are doing it.
 - ▶ State that it is for the physician's benefit as much as for yours, as it creates a good "track record" for him or her.
- Identify an appropriate monitor who understands the problem and will be seen as fair and reasonable.
- Schedule frequent meetings at first (weekly, in many cases).
 - ▶ Short meetings are fine; frequency is more important than length.
- Balance positive and negative feedback.
 - ▶ Start with the positive first, as in an intervention.
- Use objective descriptions of current behavior.
- Commend the physician for his or her progress.
- Remember that you are shaping behavior and that the physician will not do it all correctly at first.
- Consider writing periodic letters to the physician documenting his or her status and progress, or summarize your meetings in brief letters to the physician.
- Remember that positive feedback is more influential than negative feedback in changing behavior.
- View the monitoring process as an integral part of the management process.
- Use monitoring meetings as an opportunity to maintain dialogue with the physician and to provide ongoing support.

Finally, two problematic types of behaviors present fairly frequently and pose significant problems for the physician executive. First, it is not uncommon for a physician with disruptive behavior to emit similar behavior during intervention meetings regarding that behavior. How should colleagues respond? Remember that it is essential to keep these meetings under control at all times. The physician should first be reminded that his or her behavior is inappropriate and unacceptable in the meeting and should be asked to stop. If the physician does not stop in a reasonable time, the meeting should be immediately terminated. A follow-up meeting should be rescheduled at a time set by the physician in charge. Once the meeting has been terminated, it is usually best not to continue

the meeting at that time, even if the physician agrees to control his or her behavior. The physician should be told clearly that this is another example of unacceptable behavior. The behavior at that meeting then becomes an additional problem in its own right. Having some time to think about this event may serve to change the physician's perspective on his or her behavior.

The second common behavior is when the physician either threatens or carries out retribution (usually to those whom he or she thinks reported the behavior). This may be either verbal or nonverbal, active or passive. This behavior is patently unacceptable, and the physician should be told so immediately. For physicians whom the leadership suspects may act in this manner, warning him or her in advance is usually a good idea. Again, this becomes a problem in its own right and may well be cause for suspension.

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Kent E. Neff, MD, is a consultant who works with medical groups, hospitals, and other health care organizations. He was formerly the Director of the Allina Professional Assessment Program at Abbott Northwestern Hospital, Minneapolis, Minnesota.

APPENDIX I:

Principles of Partnership

PREAMBLE

The Physicians and the Hospital/Health System Staff (Staff) recognize their considerable interdependence in the rapidly changing health care environment. They acknowledge that their success in competing in the marketplace and their ability jointly to deliver high-quality health care depend in large part upon their ability to communicate well, collaborate effectively, and work as a team to optimize and monitor outcomes.

Physicians and Staff further acknowledge that there are many participants in the process of effective health care, including patients, their families, health system staff, allied health professionals, and others, and that working harmoniously with them is a necessary aspect of modern health care. Both parties affirm that everyone, both recipients and providers of care, must be treated in a dignified, respectful manner at all times in order for their mutual goal of high-quality health care to be accomplished.

Physicians and Staff further affirm that it is their mutual responsibility to work together in an ongoing, positive, dynamic process that requires frequent, continual communication and feedback. Both agree to devote the necessary time and resources toward achieving these goals and maintaining a positive, collaborative relationship between them and with other providers and recipients of care.

Principles

In order to accomplish these goals, Physicians and Staff agree to the following principles and guidelines and to work collaboratively to promote them in the organization and in the community.

1. Respectful Treatment

All members of the health care provider team (physicians, hospital staff, vendors, contract personnel, etc.) and all direct and indirect recipients of health care (patients, their families, visitors, etc.) shall be treated in a respectful, dignified manner at all times. Language, nonverbal behavior and gestures, attitudes, etc. shall reflect this respect and dignity of the individual and affirm his/her value to the process of effective, efficient health care.

2. Language

Physicians and Staff agree not to use language that is profane, vulgar, sexually suggestive or explicit, intimidating, degrading, or racially/ethnically/religiously slurring in any professional setting related to the hospital and the care of its patients.

3. Behavior

The parties agree to refrain from any behavior that is deemed to be intimidating or harassing, sexually or otherwise, including but not limited to unwanted touching, sexual touching, sexually oriented or degrading jokes or comments, requests for sexual favors, obscene gestures, physical throwing of objects, or making inappropriate comments regarding physicians, hospital staff, other providers, or patients.

4. Confidentiality

Physicians and Staff agree to maintain complete confidentiality of patient care information at all times, in a manner consistent with generally accepted principles of medical confidentiality. The parties further recognize that physicians and hospital staff have the right to have certain personal and performance problems and concerns about competence dealt within a confidential manner in a private setting. Physicians and Staff agree to maintain this confidentiality and to seek proper, professional, objective arenas in which to deal with these issues.

5. Feedback

Physicians and Staff agree to give all parties prompt, direct, constructive feedback when concerns or disagreements arise. The parties recognize the necessity of describing such behavior in objective, behavioral terms and that such feedback should be given directly to the person(s) involved through appropriate channel, in a confidential, private setting.

6. Clarification of Roles

Physicians and Staff agree that the delivery of health care involves a complex, dynamic set of roles and responsibilities and that clarity and agreement on these roles and responsibilities is necessary. Both parties agree to work together to achieve and maintain clarity and agreement on these roles and to support each other in the carrying out of these responsibilities.

APPENDIX 2:

Managing Physicians with Disruptive Behavior- Checklist of Steps

Step I: Make Rapid Initial Assessment

- Examine each report of disruptive behavior immediately; triage and get additional information if situation looks serious or urgent.
- Maintain confidentiality at all times; insist upon it from everyone.
- Make an initial determination: Is immediate action needed?
 - ▶ Patient care affected or potential for same too great?
 - ▶ Physician too distressed or out of control to be safe?
 - ▶ Serious effects upon staff, others?
 - ▶ Unacceptable legal liability?
- If “yes” to any of the above, shorten the time frame of the steps below.
 - ▶ Consider immediate action when patients or others at risk.
 - ▶ Intervene at the level of your data.
 - The initial action need not be definitive; by taking initial action you do not give up your right to take additional actions later.
- Consider a very prompt meeting with the doctor.
 - ▶ Inform physician of your initial concerns; tell him or her you will meet again soon.
 - ▶ Communicate seriousness and urgency to the physician.
 - ▶ Use this meeting as an opportunity to get the physician’s attention.
 - “Golden period” for intervention.
 - ▶ Consider immediate suspension in egregious cases.
- Involve hospital/group PHC and state PHP when appropriate (e.g., when alcohol or drug addiction is suspected or when physician might be ill or needs support).

Step II: Collect Additional Data and Complete Investigation

- Maintain confidentiality.
- Establish time frame for completion of the investigation.
 - ▶ In days, not weeks.
- Get information from multiple sources when possible.

- ▶ Consult nurses, other staff (usually best sources of information).
- ▶ Involve physicians as appropriate (not usually best sources).
- Collect objective data regarding behavior, not opinions such as what is “wrong” with him or her.
- Review incident reports and other documentation of the past behavior.
- Search for any evidence of problematic alcohol or drug use.

Step III: Assess Clinical Performance

- Assess routinely in all cases; may be brief in some excellent performers.
- Review for any clinical performance problems, documented or suspected.
 - ▶ Check with QA, UR, risk management, clinical department.
 - ▶ Look for any recent change or deterioration in performance.
- Include quality of communication, relationships with patients, staff, others.
- Evaluate physician’s workload. I.e., is workload too great to maintain quality?
- If evidence of clinical performance problems, refer to appropriate department or committee for investigation and action.
 - ▶ Do not delay—clinical performance problem takes precedence.
 - ▶ Do not allow clinical performance problems to be lost in the controversy about a disruptive behavior problem.

Step IV: Define the Behavioral Problems

- Write them down in clear, detailed language.
 - ▶ Make sure you understand the problems and have adequate data to proceed.
- Use behavioral descriptions to describe the physician’s actions.
 - ▶ Use objective, nonjudgmental, respectful language.
 - ▶ Include date, time, witnesses, etc.
 - ▶ Always refer to the behavior, not the person.
 - ▶ Eliminate emotionally charged words.
 - ▶ Do not impugn motives (assume good intentions).
 - ▶ Put in form that could be reviewed by the physician, his or her attorney, etc.

Step V: Determine Whether the Behavior Requires Action

- Decide whether or not the behavior is disruptive and why.
 - ▶ Ensure you are comfortable with any decision before it is finalized.
- Make decision promptly, and prepare to follow quickly with appropriate action.
- Take some action in almost all cases if the behavior is truly disruptive.

- ▶ May be only to inform physician of your concerns and warn him or her to avoid similar behavior in the future.
 - “We don’t want you to get into any trouble.”
- Make sure the specific action fits the infraction and level of the data.
- Do not take any action with which you do not agree or that you do not support.

Step VI: Plan and Rehearse Intervention Meeting

- Use a group (two-four, usually) of people who are significant to the physician to intervene.
 - ▶ Use only physicians, unless there is a good reason to involve others.
 - ▶ Balance group when possible so physician will not feel railroaded.
 - Consider including a colleague whom the physician would see as supportive (as long as the physician agrees with need to take action).
- Make sure the intervention team agrees with the assessment of the problem and the need to take this action.
- Determine the following in advance:
 - ▶ Goals of the meeting.
 - ▶ Outcomes that are acceptable.
 - ▶ Who should attend the meeting and who will lead.
 - ▶ Roles of those participating.
 - ▶ Where the meeting will take place (based on what you want to communicate to the physician).
 - ▶ When meeting should be held.
 - ▶ How long, approximately (set upper limit, e.g., 1 to 1-1/2 hours).
- Rehearse beforehand.
 - ▶ Decide who will say what, and in what order.
 - ▶ Ask everyone to write down what they will say and bring it to the meeting.
 - ▶ Chairman should have a practiced response to diversions.
 - “I know you are concerned about the quality of nursing on the unit. We can set up a separate meeting to talk about that. Right now we are here to talk about your behavior.”
 - ▶ Take enough time to get it right; good preparation is key to success.
- Decide consequences before the meeting.

Step VII: Take Action

- Thank physician for coming to the meeting.
- Always act in a respectful manner.

- Explain the purpose of the meeting.
- Assume miscommunication will occur.
 - ▶ Paraphrase frequently.
- Ask the physician to hear you out *first*.
 - ▶ “We called this meeting to discuss some concerns with you. We want you to hear us out first, then you will get a chance to respond. OK?” (get the physician’s agreement).
- Start by communicating the physician’s value and worth.
 - ▶ “Dr. Smith, you are a valuable member of this medical staff. We know that you have a strong commitment to your patients.”
 - ▶ Elaborate with more examples, statements of value, and positive regard.
- Then state your concerns about his behavior.
 - ▶ Focus on defining problem behaviors.
 - ▶ Give several examples of problem behavior if possible.
 - ▶ Deal with the problem behavior; do not make diagnoses.
 - ▶ Do not impugn motives; assume that the physician has good intentions.
 - ▶ Label behavior as “unacceptable” and explain why.
- Empathize with physician but remain firm that behavior must change.
- Do not get angry or accusative with the physician.
- If relevant, indicate that no retribution will be tolerated.
- At the end of the meeting, summarize and plan the next steps.
- Tell the physician the consequences of no behavior change.
- Maintain control; stop the meeting if it starts to get out of control.
 - ▶ Do not permit the physician to be abusive in the meeting.
- Remember the power of the written word.
 - ▶ Write a summary letter of the meeting to the physician.
 - Ask the physician to acknowledge that the summary is accurate.

Step VIII: Follow Up and Monitor Progress

- Always monitor the situation and have follow up meetings.
 - ▶ Good monitoring improves the chances for maintaining positive change.
- Regular, frequent follow-up meetings are usually best.
 - ▶ Meetings can be short; frequency is more important than length.
 - ▶ Initial meeting frequency = every one to four weeks; err on frequent side.
- Do the following in the meetings.
 - ▶ Tailor follow up to the nature and severity of the problems.

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- ▶ Balance positive and negative feedback.
 - Tell the physician when things are getting better.
 - Remember that positive feedback is more powerful than negative feedback in influencing behavior.
- ▶ Summarize and agree on next steps,if any.
- ▶ Confirm next meeting date.
- ▶ Always encourage the physician.

Alwin F. Steinmann, MD, FACP

Born, raised and educated in New York State, I received my MD degree from the New York University School of Medicine and completed my internal medicine residency at the Albany Medical Center. I later joined the full-time faculty in the Division of General Internal Medicine at Albany Medical College where my duties included provision of primary care to adult patients and the teaching of residents and medical students. In 1997 I became the Program Director of the Internal Medicine Residency Training Program and three years later, Vice-Chair for Academic Affairs in the Department of Medicine at Albany Medical College. In 2010 I moved to Denver, CO to accept the position of Chief of Academic Medicine at Exempla Saint Joseph Hospital, where I oversee all the graduate medical education programs.

A long-standing member of the American College of Physicians (ACP), I have served on the NY Chapter Council and chaired the chapter's Health and Public Policy Committee. Through the ACP, I have been involved in numerous advocacy activities. I have also been an active member of the Association of Program Directors in Internal Medicine (APDIM) and its parent organization the Alliance for Academic Internal Medicine (AAIM). I served on the national APDIM Public Policy Committee, including a term as Chair, and currently Chair the AAIM Advocacy Committee and am an elected member of the APDIM Council. Through APDIM and AAIM, I have had the opportunity to be involved in numerous presentations at national meetings and publications, all dealing with various aspects of health policy.

My involvement with the NY Near Miss Registry dates back to its inception and includes speaking engagements to promote the registry and serving on the Steering Committee until leaving NY in October 2010. It has been my privilege to work with Dr. Fried, Ms. Lambert, Ms. Donnelly and all the people who have made the registry possible.

My public service positions include chairing the New York State Department of Health's Prostate and Testicular Cancer Detection and Education Advisory Council and an appointment to the New York State Council on Graduate Medical Education (COGME), an advisory body to the Commissioner of Health. As a member of COGME, I have elected to serve on their Primary Care and Workforce Development, and Graduate Medical Education Reform Subcommittees. Although I have a broad interest in health policy, my activities to date have been driven by my experiences as a physician and educator and have largely pertained to graduate medical education, physician workforce and the promotion of primary care, and tobacco control.

Facilitator: Megan Davis, BA

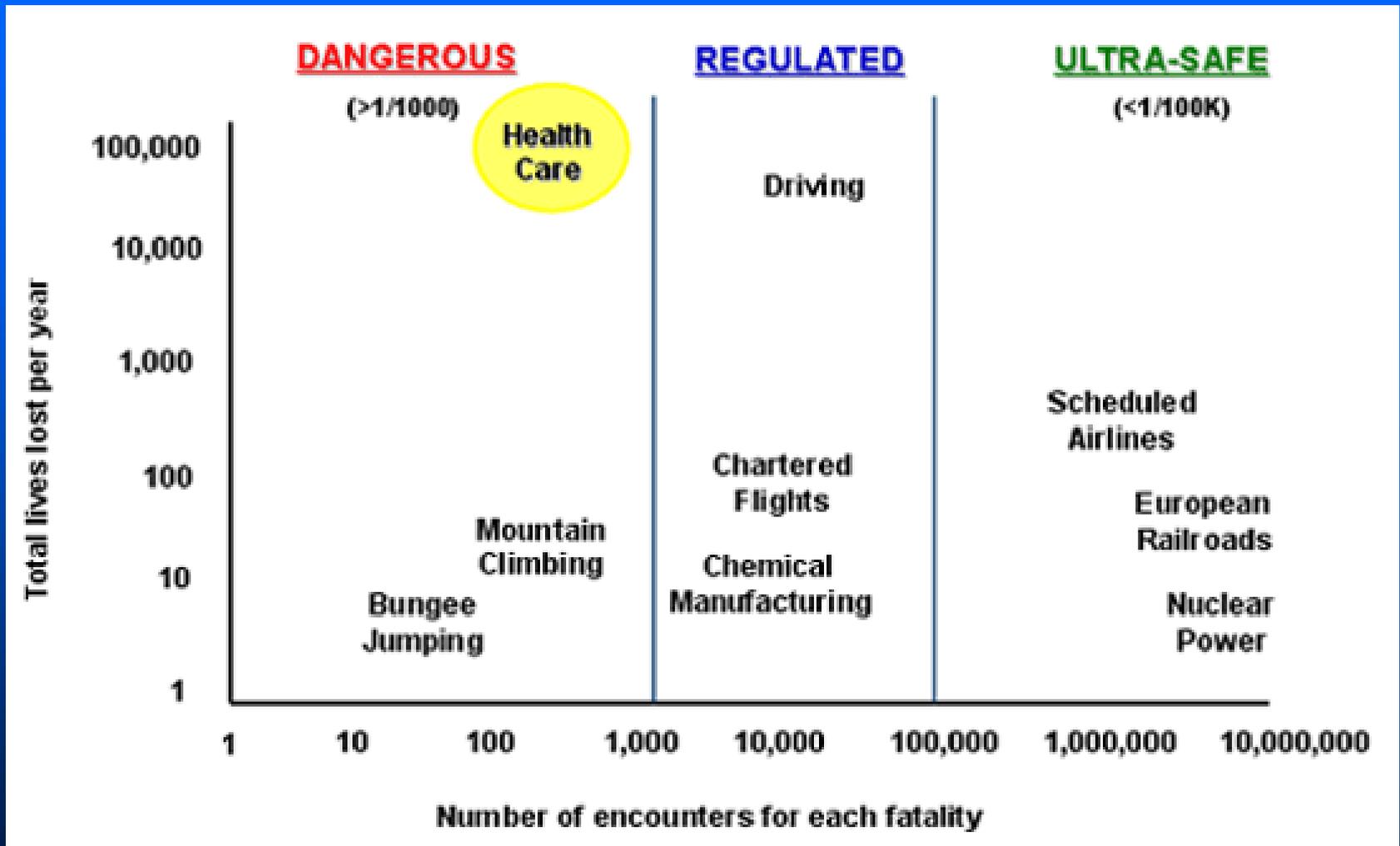
Megan Davis is a staff member of the Performance Management Center for Excellence at the Washington State Department of Health. She has been involved in performance management in state agencies since 1994. As a consultant, Megan has facilitated the development of legislation, budgets, strategic plans, performance measures, quality improvements, and progress reports.

New York Chapter, American College of Physicians NYS Near Miss Registry

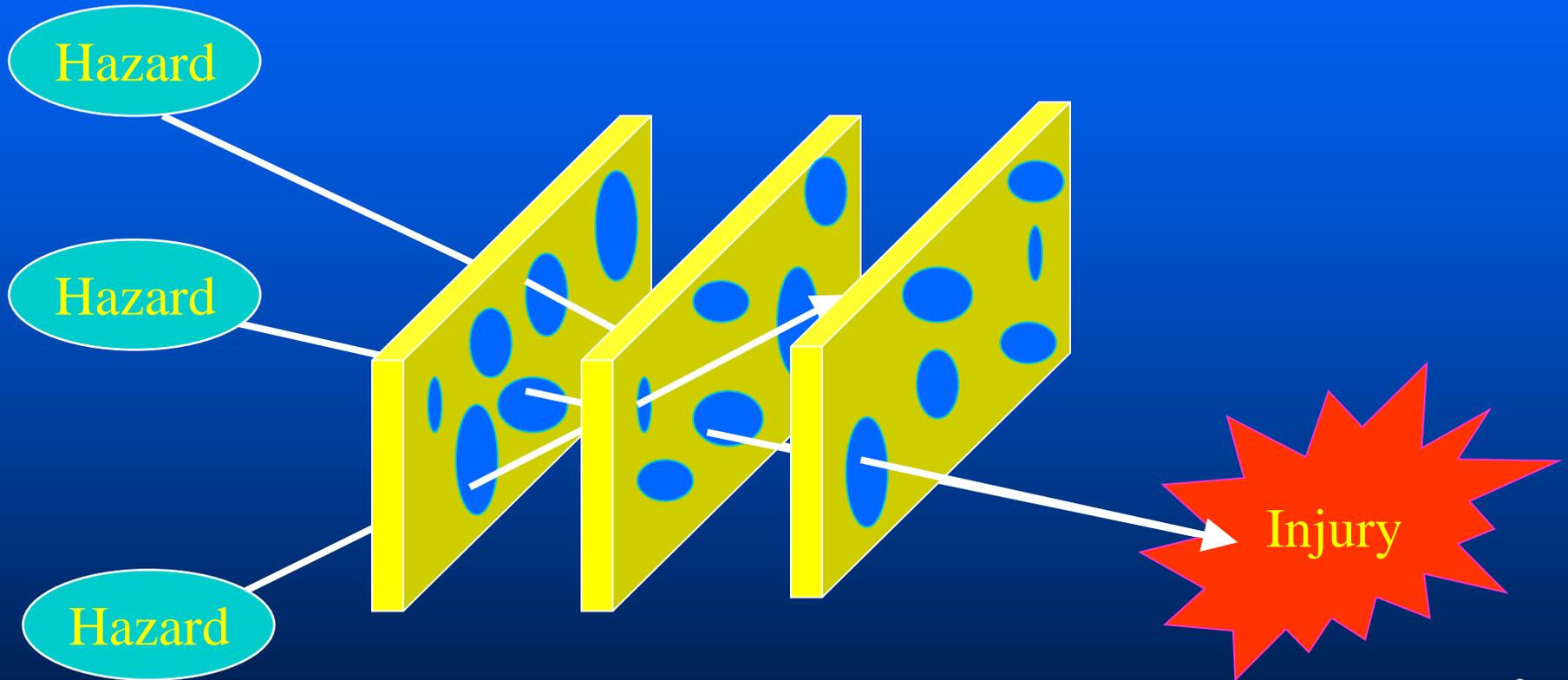
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New York Chapter American College of Physicians
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SCOPE of the PROBLEM



Medical Errors: a Complex Interplay



Bulls eye

SLIPS



Right Plan,
Wrong Action

LAPSES



Omission

MISTAKES

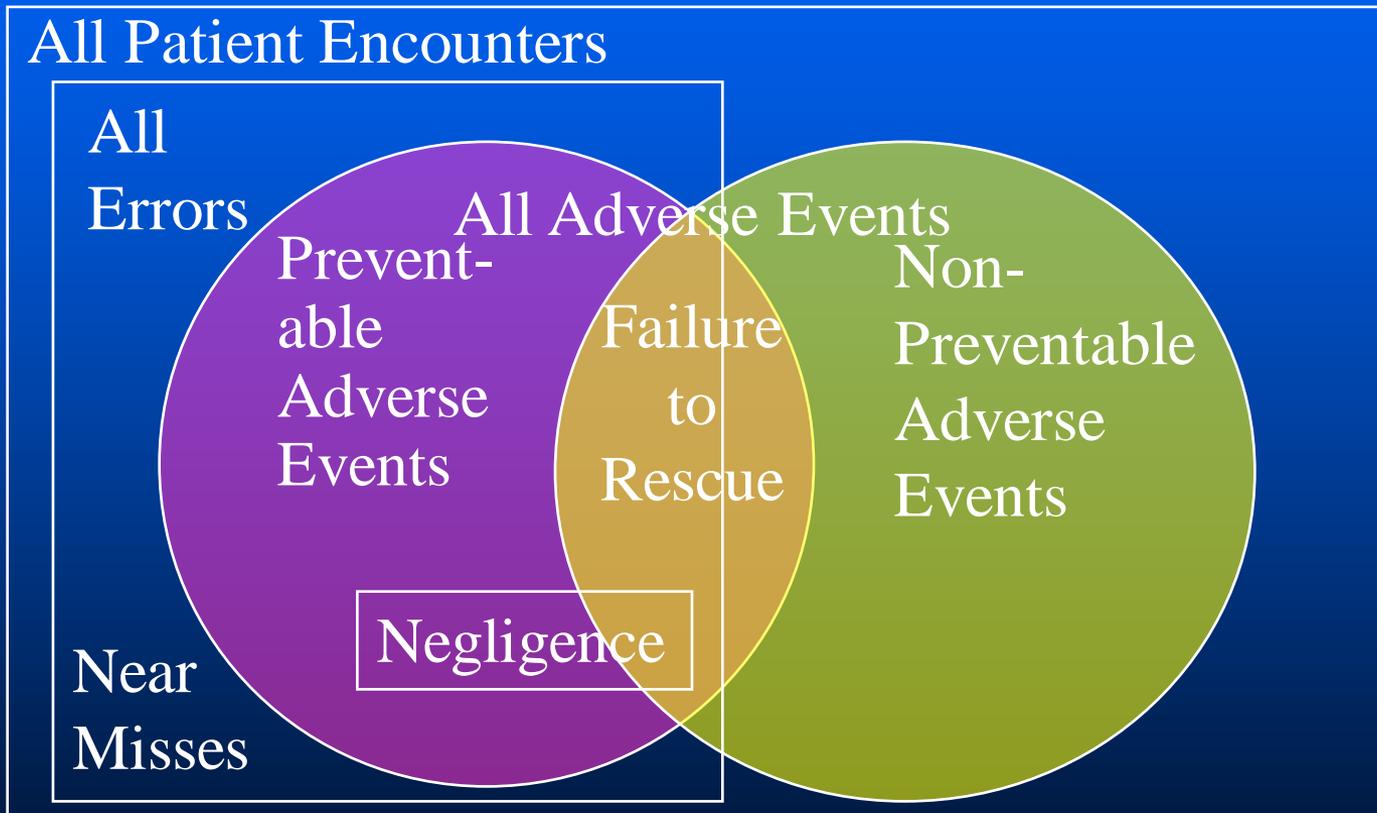


Wrong
Plan



Understanding Patient Safety

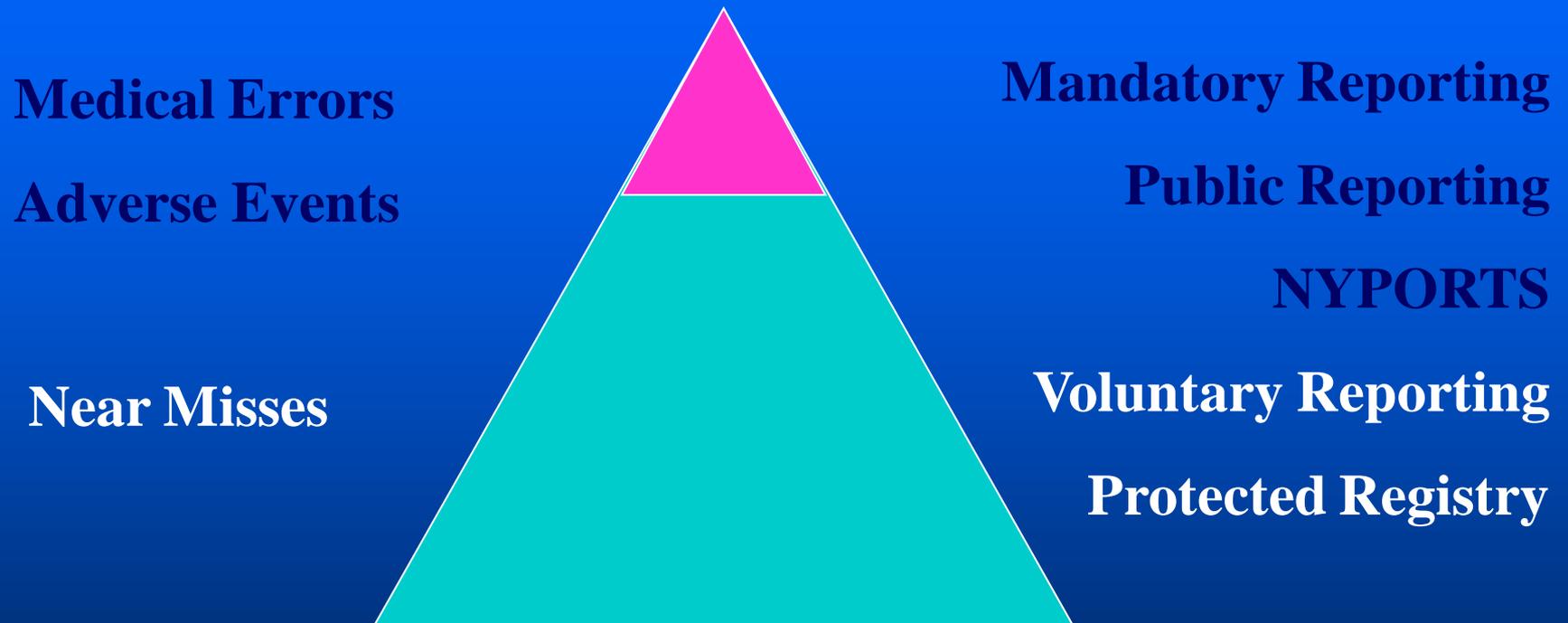
- Robert Wachter, MD, 2008, McGraw Hill



Near Miss Registry

- A voluntary, confidential, anonymous, risk free, reporting system, for the purpose of obtaining information useful for maximizing patient safety, reducing medical errors, and improving the quality of healthcare.
- **Near Miss Event is defined as an act of commission or omission that could have harmed the patient but did not reach the patient as a result of chance, prevention or mitigation. *Near misses or close calls are patient safety events that did not reach the patient. (AHRQ)***

Hierarchy of Reporting



Project's Background Information

The IOM's 1999 report *To Err is Human* brought the issue of medical errors and patient safety to the forefront of the American healthcare system. Furthermore, the Institute (IOM) recommended the development and implementation of reporting systems to identify and learn from errors, so as to prevent them from occurring in the future.

Two types of reporting systems were recommended by IOM:

1. Mandatory reporting systems, similar to NYPORTS, would collect and analyze serious incidents resulting in actual patient harm and also provide a foundation for hospital accountability.

2. Near Miss reporting systems. “When voluntary systems focus on the analysis of “near misses”, their aim is to identify and remedy vulnerabilities in systems before the occurrences of harm.

Voluntary reporting systems are particularly useful for identifying types of errors that occur infrequently for an individual health care organization to readily based on their own data, and patterns of errors that point to systemic issues affecting all health care organizations.” (IOM, “To Err is Human, 200, pg. 87)

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HISTORY

The **NYS Patient Health Information and Quality Act of 2000** (Section 2998-d of Title 2, Article 29-D of the Public Health Law), establishing the **Patient Safety Center (PSC)** within the Department, requires the Department and the PSC, in collaboration with health care providers, to develop a “**voluntary and collaborative reporting system, for the purpose of obtaining information useful for maximizing patient safety, reducing medical errors, and improving the quality of healthcare.**”

In **2005**, the New York Chapter of the American College of Physicians (NYACP) worked on a pilot project with five New York hospitals and in collaboration with the APDIM NY Special Interest Group (IM Program Directors) created a **near miss reporting system for Internal Medicine residents training in hospitals.**

CONFIDENTIALITY PROTECTIONS

In **2006**, the NYS Department of Health entered into a **three year collaboration** with NYACP that would allow NYACP to collect near miss data, on behalf of the Department and under the confidentiality provisions of Public Health Law Section 206(1)(j) to all Internal Medicine training programs in New York State.

The NYS Public Health Law provisions mean that all unidentified data that is collected is treated as data under a duly authorized research project and is not subject to discovery. This study collects data that is anonymous, confidential and is tracking unidentified information on non-events!

This research study has received **numerous IRB approvals** including the New York State Department of Health and Saint Luke's- Roosevelt Hospital Health Center.

Project Oversight

Working in collaboration with organizations such as **Healthcare Association of NYS, Greater New York Hospital Association, New York City Health & Hospitals Corporation, Committee of Interns and Residents Union**, and others the project advisory committee represents a variety of stakeholders and collaborators and meets quarterly to review the status of the project.

Project Purpose

The purpose of the Near Miss Project is to change the culture of safety to support increased patient safety activity and comfort around reporting.

Data relating to near miss events is being gathered and evaluated. Causes of near miss events are being collected and analyzed to identify patterns of near miss events and the protective barriers that prevent them from becoming errors.

Status - Analysis of Data

The Near Miss Registry is not a *hypothesis driven study*.

Rather, it is a database that will help to identify quality improvement areas to make patient care safer. Neither is the Registry a population based survey as it will rely on the voluntary contributions of the residents who receive education and training.

At regular intervals, the **data is being analyzed:**

- **First a descriptive analysis** is being performed.
- **Next** , near misses are categorized as a **slip, lapse or mistake; and protective barriers** are being isolated in relation to the type of near miss event.
- **A third analysis** will attempt to relate **certain characteristics** of different hospitals, settings or patients to particular types of near misses and/or barriers.

The analysis and evaluation is being conducted by a well established researcher from SUNY Albany, School of Public Health

NM Registry: Key Facts

- Conceived in 2004
Pilot in 2005 (St. Luke's-Roosevelt, Lenox, St. John's Episcopal, Staten Island, NY Downtown) about 57 reports in 6 months
- Formal partner with NYS DOH in 2006.
- Phase 1 2007-2009 with residents in internal medicine
- Trained over 3000 IM residents in 43 teaching hospitals from Buffalo to Long Island.

NM Registry Phase 1

- Collected 287 reports
 - More than 50% medication errors
 - 28% of those concerning anticoagulation
 - More than half discovered/corrected through Medication Reconciliation.
 - Rest wrong patient/policy breaches plus others.
- Errors fall in to a pattern with increasing "sophistication" of institution. (CPOE introduces its own class of errors).
- 23 key words pulled from verbatim descriptions of errors - will form the basis of a "common phraseology" of errors that will help with interpretation of next phase.

NM Registry Phase 2

- Phase 2 began Jan 2010.
- Survey expanded to residents in specialties other than IM.
- Future plan is to expand to other health professionals.
- Survey was revised to be more useful for other healthcare worker roles based on multiple focus groups.
- Data remains protected by state research waiver 206(1)(j).
- Project remains covered by NYSDOH IRB and SLR IRB.
- NYACP is in discussion with individual hospitals that are currently collecting their own near miss data to transfer their information into the aggregate state wide registry.
- The data will also have the legal confidentiality protection under NYS Public Health Law 206(1)(j).

The Near Miss Survey

@

www.nearmiss.org

18

Always Putting Patients First Near Miss Tracking Registry

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Wednesday, July 01, 2009

Login

Welcome.

Login ID:

Sign In

Near Misses are those events that might have resulted in harm to a patient but were discovered and corrected before they ever reached the patient.

Goal

The New York Chapter of the American College of Physicians (NYACP) and the New York Special Interest Group of the Association of Program Directors in Internal Medicine (APDIM-NYSIG) are working with the New York State Department of Health to **collect data relevant to "near misses" in patient care in a safe, anonymous and risk-free environment**. Through this web based tool, we hope to prove that voluntary, anonymous reporting is an effective way of identifying vulnerabilities in our health systems and learning about the strength of the barriers that protect patient from harm.

Confidentiality

The Near Miss Survey data **is being held securely** in a server belonging to the New York Chapter American College of physicians. All non-identifiable responses related to the survey **are privileged as quality research information under section 206 (1) (j) of the New York State Public Health Law.**

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Near Miss Tracking Registry

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NYSIG Association of Program Directors
in Internal Medicine
New York Special Interest Group

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Thursday, December 20, 2007

Section A - Demographic Information

Near Misses are those events that might have resulted in harm to a patient but they were discovered and corrected before they reached the patient. Medical errors that reach a patient with or without adverse effects must be managed through the hospital's policies and procedures, and potentially submitted by the hospital to the New York Patient Occurrence Reporting and Tracking System (NYPORTS).

A1) Did the error reach the patient?

- Yes
- No

A2) Indicate your role in healthcare

- Training Program or Associate Director

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Thursday, December 20, 2007

Thank you for participating, you have indicated that the error reached the patient.
Please immediatly report this incident to the Program Director, hospital quality improvement or risk management office.

If this is not true and you would like to return to the survey [click here](#).

Survey

- **Demographics**
 - Role in Healthcare
 - Type of community
 - Size of the facility
 - Type of patient care environment
 - Night float
 - CPOE
 - EMR (HER)
 - Bar Coding
 - Date, time
 - Day of week
- **Patient**
 - Service vs. Private
 - Age range/Gender
 - Department

Survey (2)

- The error
 - Who made the error/Discovered the error?/
When?/Weekend? Night?
 - Error Category and Description
 - Near Miss Event Reporting (**Free text**)
 - What were the barriers that protected the patient?
(**includes free text**)
 - System based contributors to error, barrier
- Ease of use of the survey/feedback
- CERTIFICATE!

Systems Based Practice Certificate



Learn & Doing Matters First
Near Miss Tracking Registry

ACPP
American College of Physicians
Internal Medicine
Doctors for Adults

WVSIG
Western Veterinary Society
Internal Medicine
Doctors for Animals

APDIM NYSIG
Association of Program Directors
in Internal Medicine
New York State Chapter

Congratulations!

You have successfully added a report to the NYACP - APDIM NYSIG Near Miss Tracking Registry. Your contribution to this registry will help us to understand the hazards that face our patients and the barriers that prevent near misses from becoming medical errors.

Reporting a "near miss" is a fundamental part of demonstrating competency in "SYSTEMS BASED PRACTICE". In Systems Based Practice we acknowledge that medicine is practiced in the context of a larger system made up of many processes. Understanding and recognizing when things could go wrong is the first step in creating a more robust and safe environment for our patients.

This activity can be credited toward one or more of the six general competencies as described by the Accreditation Council on Graduate Medical Education.

You may print this page out, write your name on it and give it to your program director to document your participation in this survey. The certificate will NOT allow anyone to trace your entry or identify your data but only serve to certify that you have contributed to this important "systems based practice" measurement tool.

Keep up the good work and we hope you will visit the registry again!

Name: _____ Date: _____



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10/22/2000

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INTERNAL MEDICINE *Doctors for Adults*

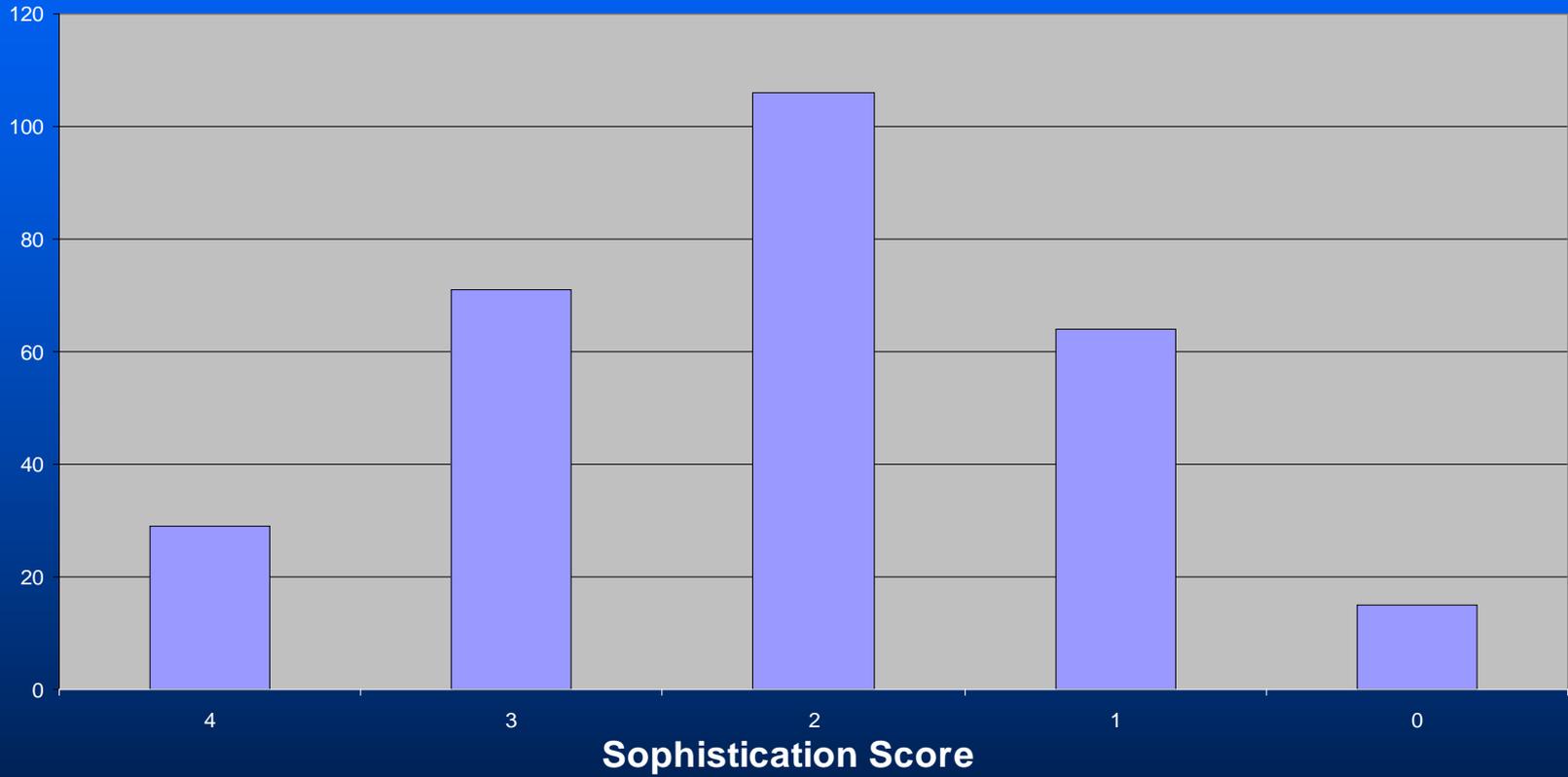
Questions?

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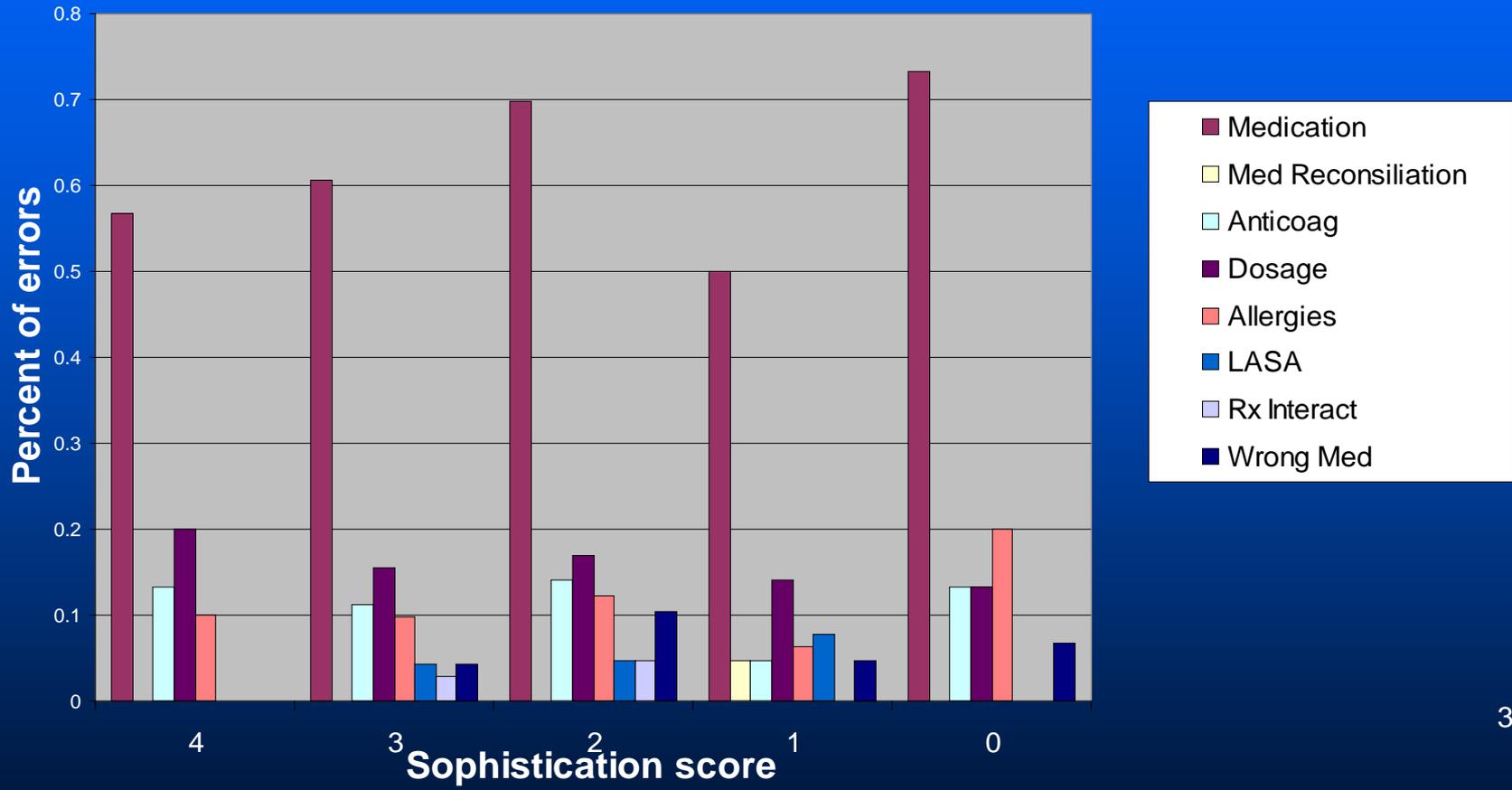
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE. *Doctors for Adults*

Number of Errors Reported

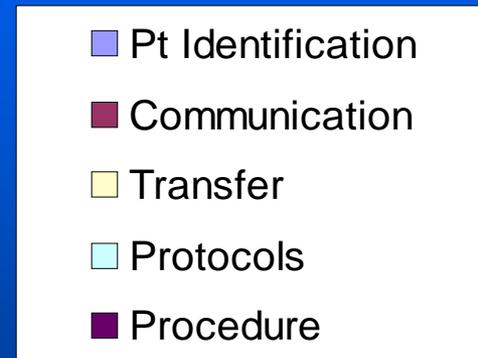
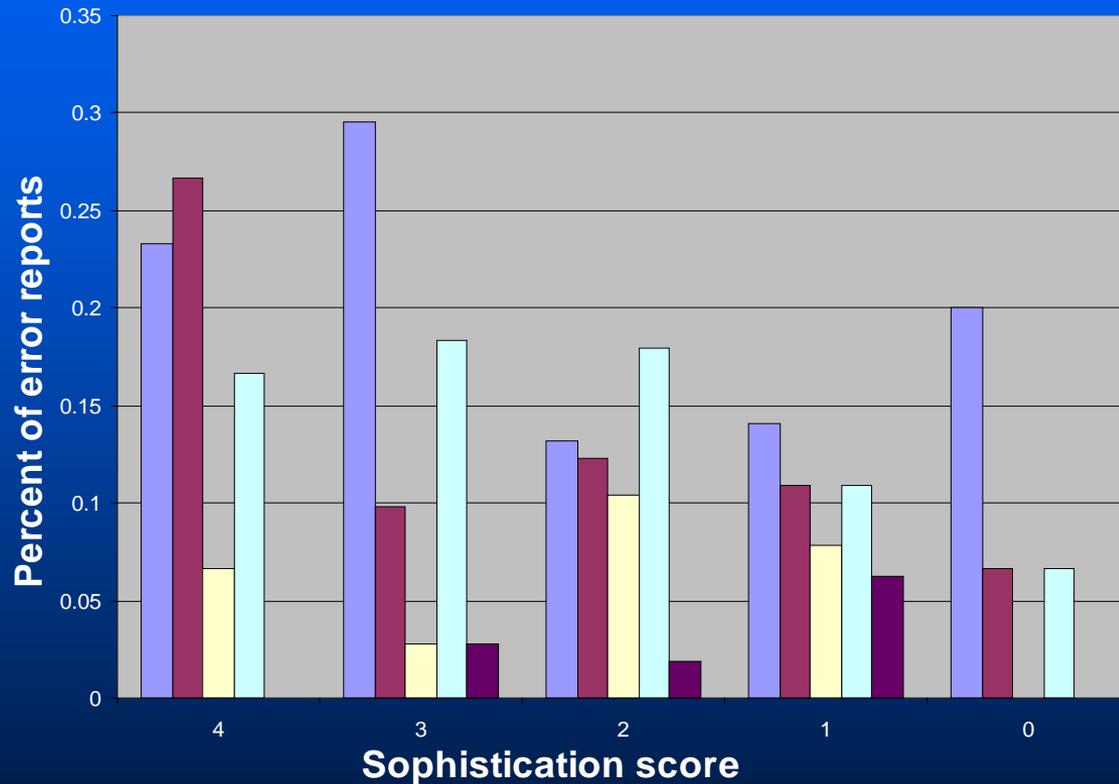


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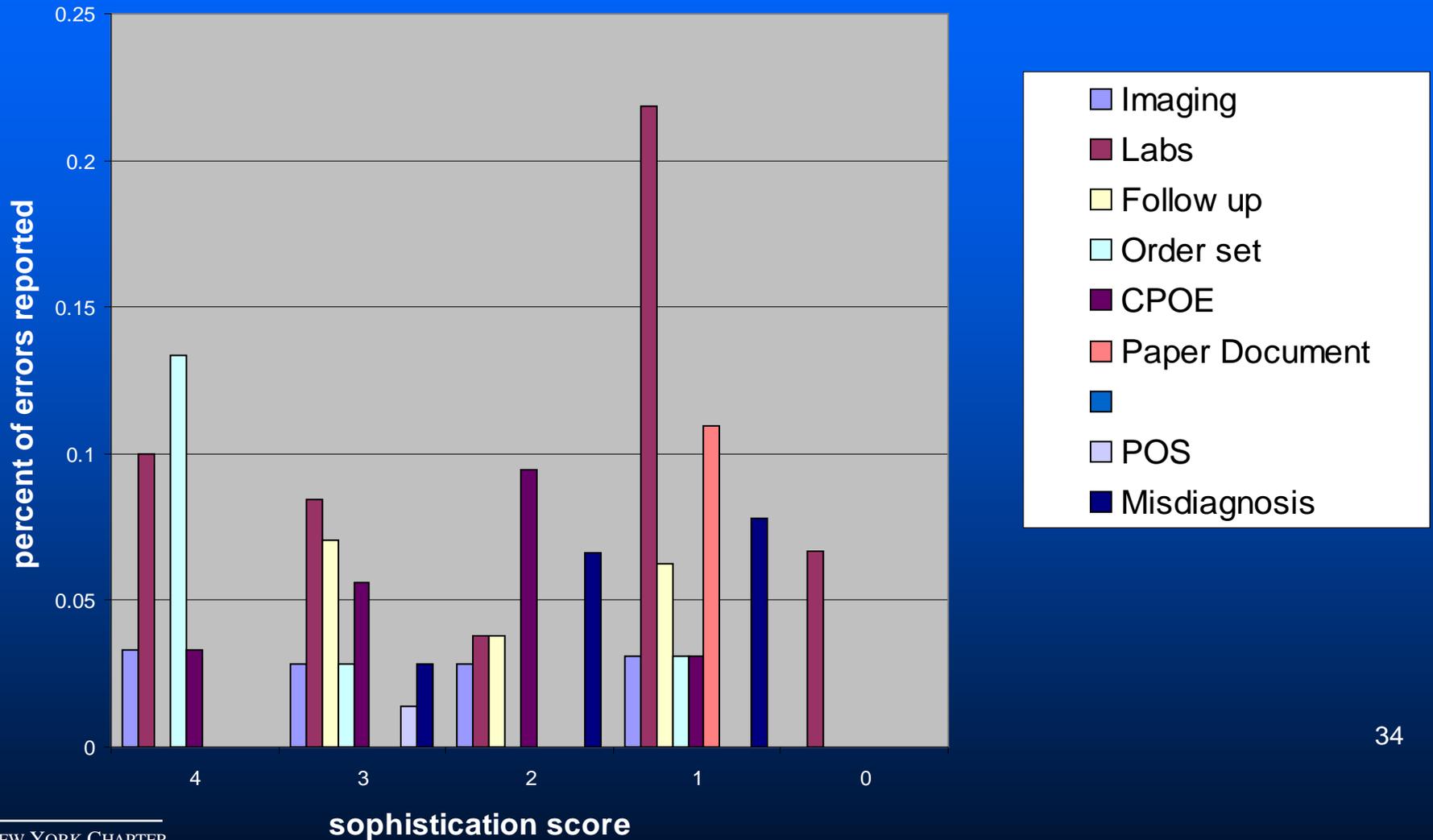
Medication errors by Sophistication



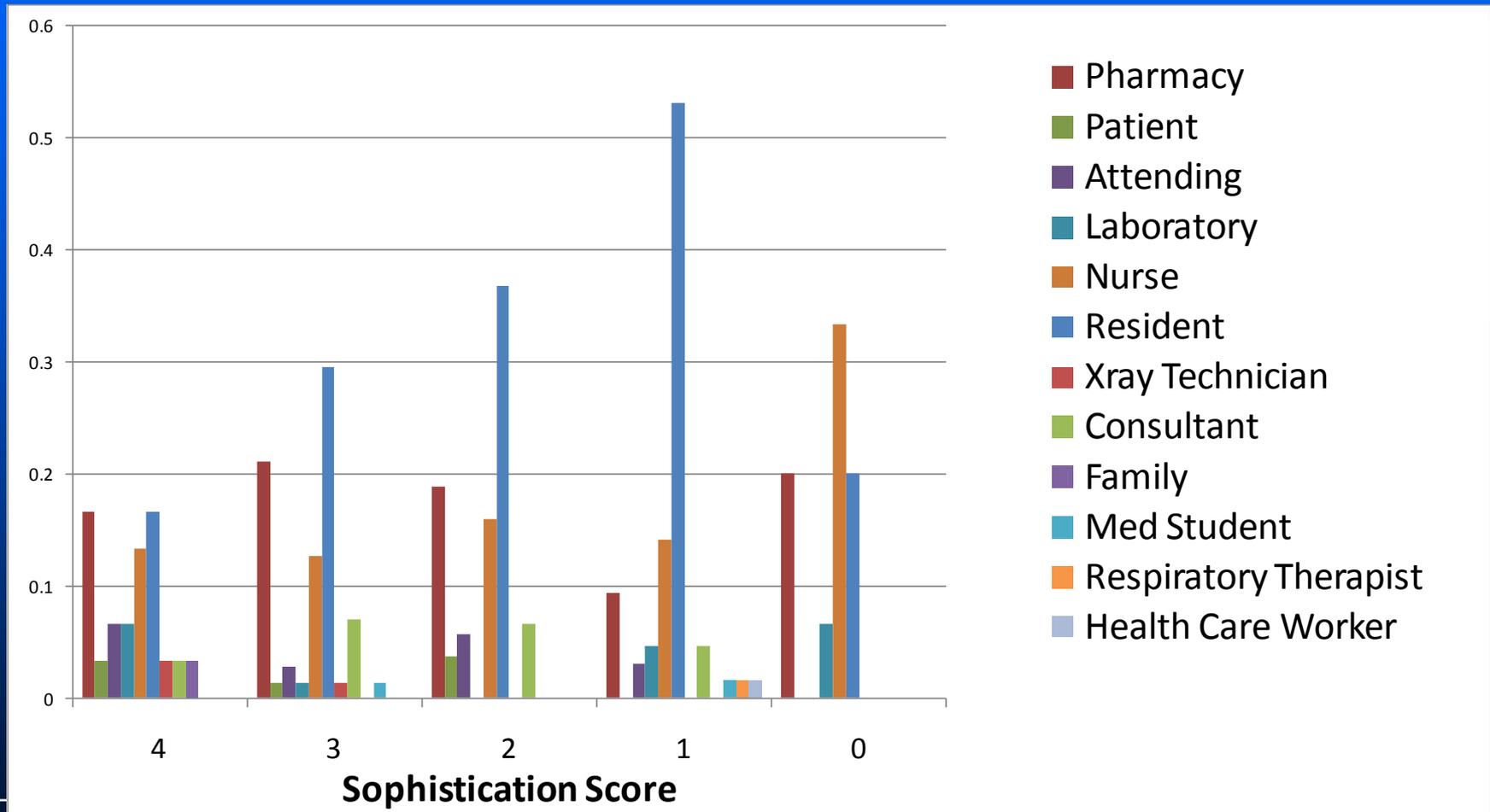
Systems errors by Sophistication



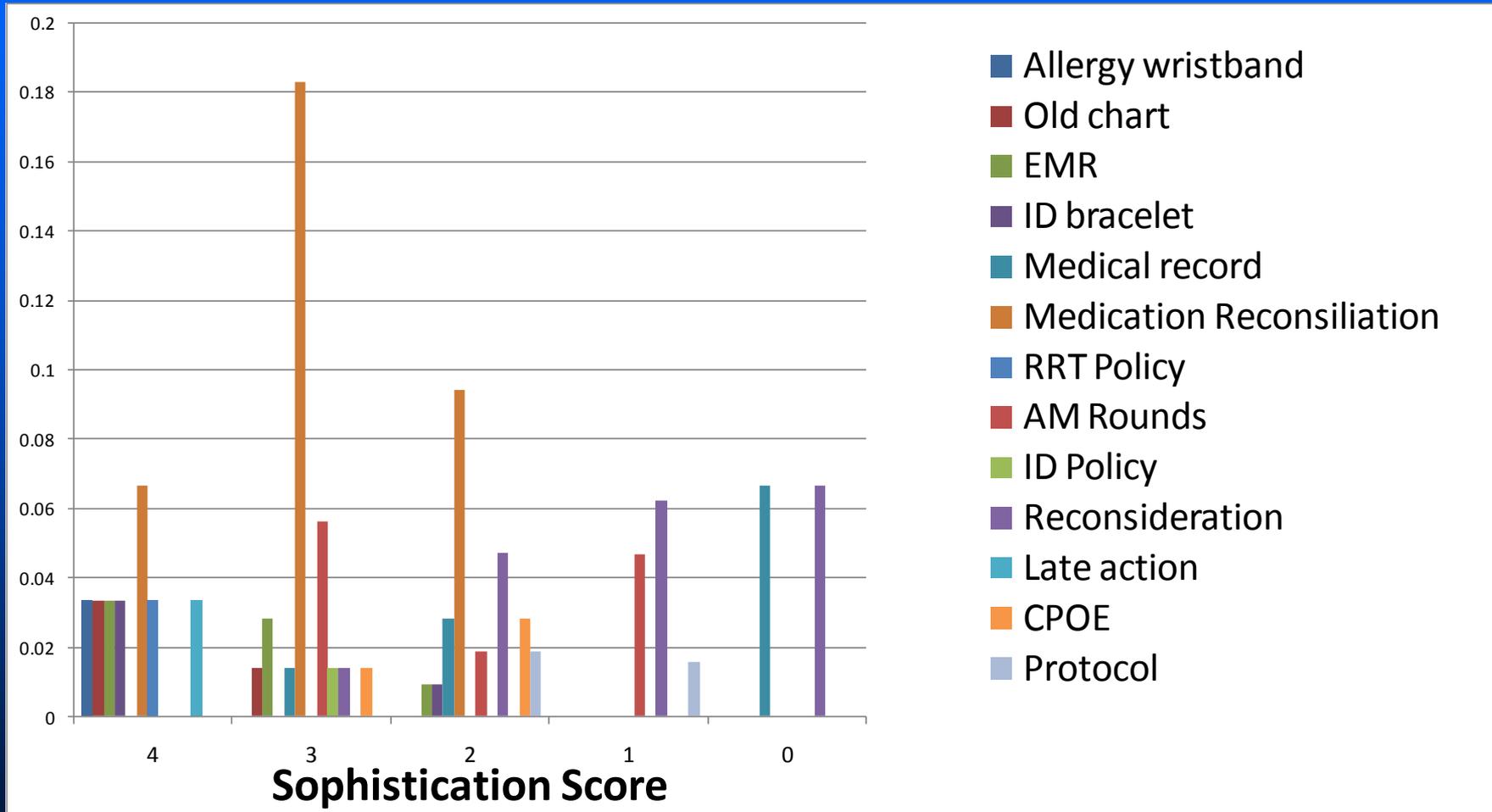
Service related errors by sophistication



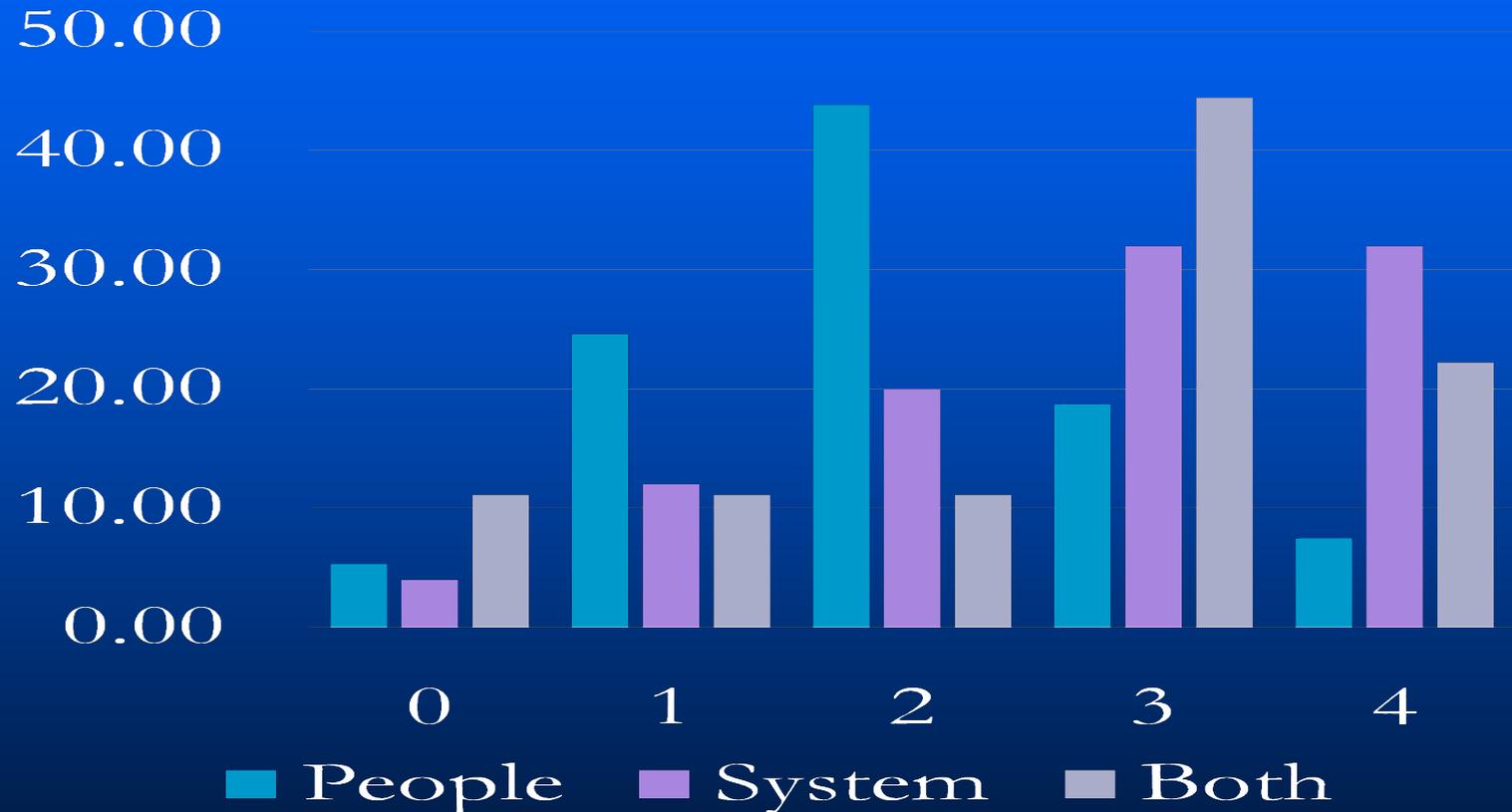
Human Barriers by Sophistication



Systems Barriers by Sophistication

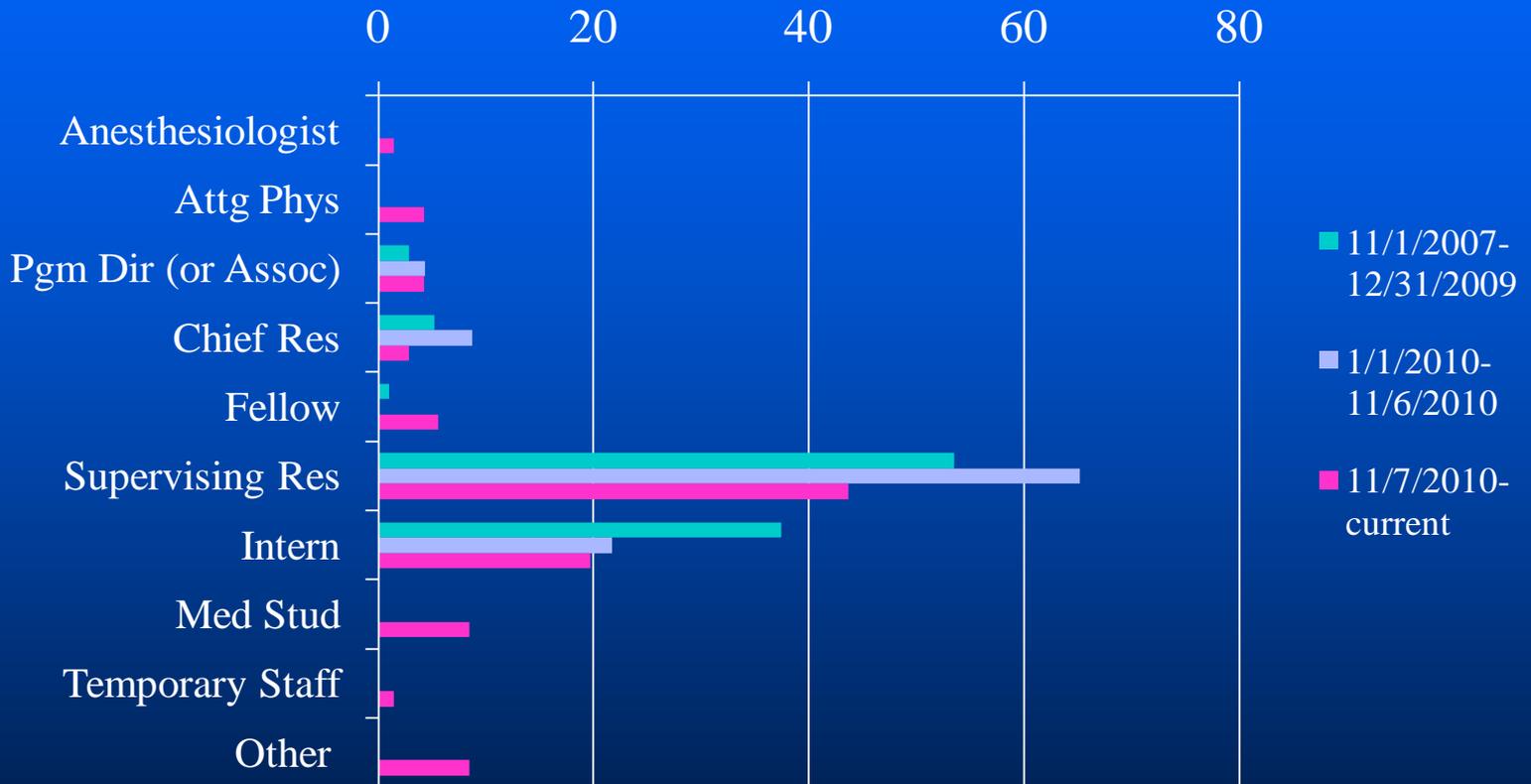


Survey Barriers by Sophistication (Near Misses Only) $p < 0.0001$



37

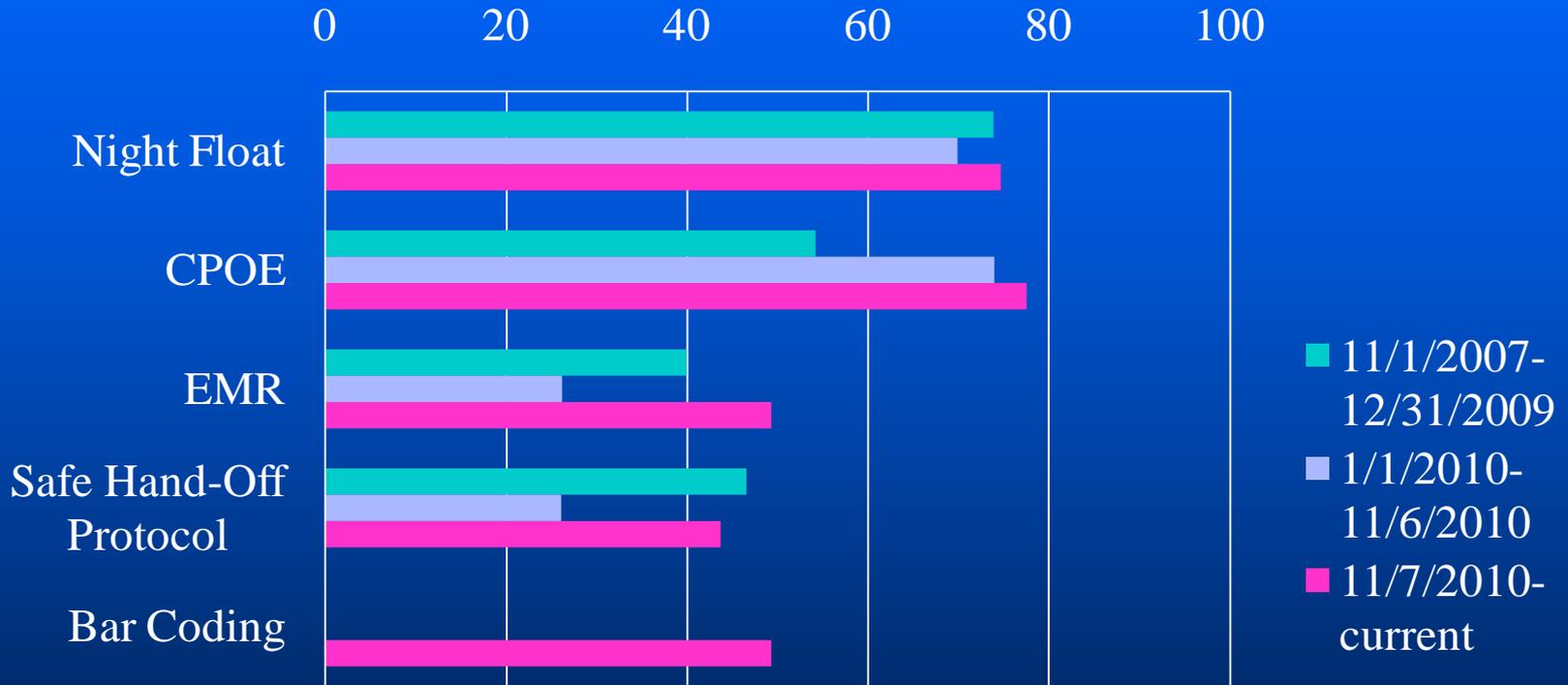
Reporter: Phase 1 vs. 2



Location



Safety Systems



NYS Near Miss Registry

Newsletter

VOLUME II
ISSUE 1

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NYS Near Miss Registry Update

By *Ethan Fried, MD*

Overview

The New York State Near Miss Registry is an online voluntary, confidential, anonymous reporting system that collects near miss reports. A near miss or a close call is an act of omission or commission that could have harmed the patient but did not reach the patient as a result of chance, prevention or mitigation. The project's objective, patient safety training of interns, residents, hospitalists and attending physicians and other allied health professionals, can assist hospitals by helping to develop a "just" culture of safety that results in increased reporting, identification of system issues detrimental to patient safety, and of existing barriers that prevent errors from occurring.

Background

In 1999-2000, the IOM in "To Err Is Human" recommended that the development of voluntary reporting efforts should be encouraged (Recommendation 5.2). The IOM believed there was a role for mandatory, public reporting systems and voluntary, confidential reporting systems. However, because of their distinct purposes, such systems should be operated and maintained separately. "Voluntary reporting systems, which generally focus on a much broader set of errors and strive to detect system weaknesses before the occurrence of serious harm, can provide rich information to health care organizations in support of their quality improvement efforts. Near miss systems aim to remedy vulnerabilities in systems before the occurrence of harm.

2010-2011 Update

From 2007 - 2009, reporting was initially limited to residents trained in internal medicine (IM) in NYS hospitals. In 2010, the near miss survey was modified and the program was expanded to include reports from all physicians in all specialties and all health related professionals. In 2010 alone, over 1500 physicians in New York State received patient safety training. The 2007-2009 and 2010 data findings are included in Table I. A listing of the free text 2010 near miss medical events responses can be found in Table II. We are currently reviewing and analyzing the 2010 raw data.

*Near Miss Registry Data Findings
and Medication Related Near Miss
Events Included on Pages 2-4*

In This Issue:

- Page 2 - Registry Year to Date Data Findings*
- Page 3 - Medication Related Near Miss Events*
 - FDA Medication Alert
 - Quality Awards
- Page 4 - NYACP Quality Improvement Plan*
- Page 5 - Results: Best Practices, Lessons Learned*
- Page 6 - Anticoagulation Online Resources*

Important Facts

The Near Miss Registry is an anonymous, risk free reporting system for near miss medical errors. The data it is designed to collect would have never otherwise been collected. The New York State Department of Health has issued a research waiver that protects anyone that submits de-identified data to the near miss registry.

The Near Miss Registry has received IRB approvals from the New York State Department of Health and St. Luke's Roosevelt Hospital.

The Near Miss tool is located on a secure Web site, under the auspices of the New York Chapter of the American College of Physicians @ www.nearmiss.org

The Near Miss Project was open for reports on 8/1/07. Effective 11/7/10, the registry is open to all NYS Interns, Residents, Hospitalists and Attending Physicians.

Upon survey completion, the submitter can receive a certificate that may qualify as documentation for "Systems Based Practice" training requirements. The certificates do not identify the nature of the submission, but merely documents that a report was filed and that by identifying and reporting a near miss, the reporter is recognizing the "systems based" aspects of patient care.

NYS Near Miss Registry YTD Data Findings

Question	2007-2009 Findings	2010 Findings
N =	287	63 Total = 350
Size of Facility	> 300 beds (79%)	> 300 beds (73%)
Hospitals w/ a CPOE	54%	73%
Hospitals w/ EMR	41%	43%
Hospitals w/ Bar Coding	Not Asked	45%
Hand off Protocols	56% Paper 26% Supervised Verbal 0% Unsupervised Verbal 12% Electronic	41% Paper 24% Supervised Verbal 13% Unsupervised Verbal 8% Electronic
When Discovered	Immediately or within 1-3 hours	Immediately or within 1-3 hours
Near Miss not reported to anyone	10%	30%
Near Miss Report Types	39% Slip 27% Lapse 10% Wrong Plan 5% Breach of Protocol	57% Slip 24% Lapse 6% Wrong Plan 6% Breach of Protocol
Most Common Event Reported	42% Medication 26% Wrong Dose 18.8% Anticoagulation 17% Allergies 14% Communication 12% Wrong Patient	35% Medication 13% Communication 11% Wrong Patient
Protective Barriers	Primary Team Nurse Pharmacist Coverage Team	Pharmacy Primary Team Nurse
Recommendations for Preventing Near Misses	27% Availability of electronic data 27% Education Intervention	30% Availability of electronic data 19% Education Intervention
Medical Staff on Duty > 16 Hours	6.3%	3.17%
Important Survey is Anonymous	97.5% Agree	98% Agree
Format of Survey was Easy to Follow	97% Agree	97% Agree

2010 NYS Near Miss Registry Medication Related Near Miss Events – Table II.

Category	Drug	Event
Antibiotics		
	PCN	PCN ordered for Patient who was allergic to the med
	Ceftriaxone	Prescribed for enterococcal infection (UTI/Bacteremia)
	Unknown	Two admissions at same time, one with CHF & another with cellulitis; antibiotics ordered for wrong patient
	Kefzol	Pt forgot that he was allergic to Kefzol
	Vancomycin	Ordered 500 GM instead of 800 mg.
Narcotics		
	Oxycodone	Written when pt. has allergy to med
	Oxycodone	Pt. discharged with prescription written for 10 x amount intended to receive. Intern did not double check or have supervising resident review prescriptions.
	Fentanyl drip	Ordered on wrong patient due to wrong patient record being opened on computer screen.
Misc.		
	Unknown	Medication ordered for wrong patient on electronic order entry
	Unknown	Documentation of a drug order on wrong patient
	Medication	Allergic Reaction in ER noted in ED note but not recorded in computer system. Patient placed on drug upon discharge by attending MD
	Potassium	Fatigued resident on long call & very tired. Mistaken thought K level was too low and ordered K replacement. Pt actually had flagged high K level
	Potassium	Order written on wrong patient - Pt had same name as another patient in ICU
	D/C Meds	Discharge medication prescriptions had wrong name of patient
	Unknown	Order written & explained to nurse regarding meds- followed in reverse order.
	Unknown	Allergy for a patient was not identified by admitting intern, and subsequently ordered for patient.
	D/C Meds	Patient was discharged on prehospitalization medication dose, should have been increased as what he was receiving currently in hospital.
	Unknown	Wrong Dose written by medical intern
	Unknown	Medications had expired
	Lamivudine	Was about to order Lamivudine but I really wanted Lamictal
	Glypside	Ordered for tid when the patient was taking it bid
	Hydroxyurea	Given w/o consented for tumor lysis syndrome
	Haldol	Picked up on EKG; if pharmacy alert required for additional haldol it would have helped early identification.
	Haldol	Patient had history of dystonic reaction

FDA News Update – Medication ALERT

Propoxyphene (Darvon and Darvocet) has been withdrawn from the U.S. market at the request of the U.S. FDA after a new study showed that the medication puts patients at risk for potentially serious or fatal heart rhythm abnormalities. The FDA determined that the medications' risks outweighed their benefits to patients. Physicians have been advised to stop prescribing and dispensing propoxyphene products. Physicians are being asked to contact patients who are currently taking the medications to discontinue use and discuss other pain management alternatives.

Quality Awards

The following hospitals recently received the **NYACP Quality Award** "in recognition of the completion of Near Miss Patient Safety Training thus Creating Culture of Patient Safety and Demonstrated Commitment to Excellence in Systems Based Practice that Supports, Nurtures, and Enhances Patient Care."

- Beth Israel Medical Center
- Creedmoor Psychiatric Center
- Ellis Hospital
- Interfaith Medical Center
- Lincoln Medical & Mental Health Center
- Lourdes Hospital
- Mount Vernon Hospital
- Nassau University Medical Center
- New York Downtown Hospital
- St. Barnabas Hospital
- South Nassau Community Hospital
- United Health Services Hospital
- Unity Hospital

2010 NYS Near Miss Registry Medication Related Near Miss Events

Table II...Continued

Category	Drug	Event
Anticoagulation		
	Lovenox	Lovenox dose ordered bid - received first dose @ 7pm; cancelled 2nd dose due @ 10pm.
	tPA	TX. for DVT Thrombosis, almost received three times the adequate dose.
	Heparin	Non English speaking pt. admitted with weakness & HPT; attending told intern to discharged pt.; CT scan ordered due to c/o headache; diagnosis =Internal Cranial Bleed
	Heparin	Failure to order anticoagulation therapy in patient admitted for DVT
	Heparin(LMW)	Patient had platelet abnormality
	Coumadin	Not restarting Coumadin for a patient with St. Jude Mitral Valve Replacement
	Coumadin	Pt. discharged on 15mg of Coumadin as opposed to 5mg.
	Warfarin	Pt. ordered a dose of warfarin based on INR > 24 hours old due to delay in drawing new INR.

NYACP Quality Improvement Action Plan

According to the 2007-2009 New York State Near Miss Registry data, drug administration (48.3%) is the most common near miss event reported by Internal Medicine Interns and Residents. Out of these near misses, 26% of the reported incidents relate to wrong dose and 18.8% involve anticoagulation therapy.

STEP 1.

A call for “**best practices**” for anticoagulation acute treatment therapy and dosing. We will highlight “unique practices”, currently employing methods to address this area of systemic need.

STEP 2.

NYACP is seeking those **IM training programs who may be interested** in participating in a **pilot project** that involves administering a brief pre-test and post- test to verify that the anticoagulation educational learning objectives have been met. Contact Mary Donnelly at mdonnelly@nyacp.org if you are interested.

STEP 3.

NYACP will offer a 1 hour **Anticoagulation Administration Training Webinar** on Friday, April 29, 2011 for interested training programs. Register online at www.nyacp.org/meetings. Following the webinar, a presentation with lecture notes will be made available on the NYACP web site.

Anticoagulation Dosing Training

As part of a system wide approach to education and action, NYACP is implementing a series of steps to address this area of patient safety vulnerability.

RESULTS: Call for Anticoagulation “Best Practices” and Lessons Learned

Kings County Hospital

“It has been suggested that **CPOE with decision support** improves patient safety and reduces medication errors. CPOE order sets and collections of pre-formed quick orders streamline the ordering process, improve CPOE efficiency, and improve adherence to proper dosing guidelines. While evidence-based guidelines are useful for initial development of order sets, a multi-facility interdisciplinary team was crucial to resolve many practical issues that arose during the design and implementation of the system.” **Abha Agrawal MD, FACP, at Kings County Hospital Center, NY**, in her paper titled, “*Design, Development and Implementation of a Computer-Based Anticoagulation Order Set with Embedded Decision Support*” describes the steps that were taken @ Kings County Hospital to optimize ordering and anticoagulation management. The paper includes dosing guidelines for Heparin, Dalteparin, Enoxaparin and Warfarin administration with source references that were incorporated into the computerized physician order entry system.

Lincoln Medical & Mental Health Center

Initially a **baseline evaluation** of anticoagulation practices was conducted by the **Pharmacy & Therapeutics and Drug Utilization committees**. Additional opportunities identified using FMEA and GAP analysis process. Interventions were designed by an interdisciplinary committee and included: incorporation of a clinical decision tool with dosing guidelines and **electronic order sets within the CPOE**, automated referrals to dietitian; **Compiled a comprehensive anticoagulation manual and clinical staff was educated on best practices with yearly competency assessment, pharmacy reviews 100% of anticoagulant orders concurrently to monitor and advise on best practices, developed patient education materials and translated them** into Spanish and top 12 languages of patient population, created a **patient registry** to ensure f/u in ambulatory care with **process redesign** for tracking, recall and clinic visit structure, adopted point of care testing for INR. **Multiple performance improvement projects were designed to measure and share success and opportunities**. Lessons learned- Implementing a comprehensive anticoagulation program requires interdisciplinary commitment, collaboration, and ongoing education. Developing process and outcome measures is important to address successes and opportunities for improvement.

Maimonides Medical Center

Anticoagulation Best Practices included **standardization of a risk assessment** and utilization of a **mandatory** risk assessment in an existing **CPOE system** to ensure appropriate prophylaxis therapy compliance. Lessons learned were: Implementing standardized protocols is an effective means to reduce the incidence of DVT and PE; early end user feedback prior to and following implementation of a new process is necessary and physician consensus when utilizing evidenced based practice guidelines is essential for success.

South Nassau Communities Hospital

Anticoagulation Best Practices – **systems redesign – physician consensus on standard of care, standardized chemoprophylaxis orders and pharmaceutical patient education discharge kits**. Lessons learned – The simpler the better; for program to be effective , hospital administration, clinical leadership and medical staff initiative (differing opinions regarding the standard of care)must be aligned and committed to the improvement initiative, and physician compliance increases with ongoing mandatory education and awareness programs for medical staff.

Stony Brook University Medical Center

Anticoagulation Best Practices – **standardize assessment tool, an electronic patient record solution** that deploy improved processes which **utilized** NQF recommendations, Joint Commission Standards and American College of Chest Physicians **established guidelines and hard stop forced function technology**. Lessons learned - Utilizing electronic solutions allows for the ability to hardwire systematic processes , such as “real time” specific lab alerts and an automatic lab monitor ordering to drive compliance, utilizing a “hard stop” locked function which provides a solution to control the process to ensure systematic deployment, a house wide initiative requires consensus process to ensure “buy-in with process changes, and more importantly to address key patient requirement and practitioner needs to maximize patient care and outcomes.

For more detailed information on these anticoagulation best practices and lessons learned, please visit: www.nyacp.org/nmbestpractices

We would like to thank Nancy Landor for submitting information on the hospitals who recently received the HANYS Quality Institute 2010 Pinnacle Award for Quality & Patient Safety. Congratulations to all!

Show Your Support for Patient Safety and Submit a Near Miss Report to the Registry Today!

HOW TO SUBMIT?

Submit a Near Miss Event to the Near Miss Registry online @ www.nearmiss.org by entering the word near miss in the login box.

WHAT IS A NEAR MISS?

It is a “close call” patient safety event that DID NOT REACH THE PATIENT due to chance, mitigation or prevention.

WHY IS IT IMPORTANT?

Near Misses may have the same root cause as actual adverse events. An adverse event is an injury that did reach the patient as a result of medical care. Identification of Near Misses can help correct problems before they become adverse events.

WHO CAN REPORT?

All physicians, including Interns and Residents, from all medical specialties in New York State

IS IT SAFE?

Your Report is Protected. All de-identified reports to the Near Miss Registry are protected from disclosure by NYS Public Health Law 206 (1) (j).

Anticoagulation Online Resources

National Guidelines Clearinghouse

<http://www.guideline.gov/search/search.aspx?term=anticoagulation+therapy+guidelines>

IHI High Alert Drugs (includes information on an anticoagulation toolkit and resource center)

<http://www.ihl.org/IHI/Programs/Campaign/HighAlertMedications.htm>

Institute of Safe Medicines Practices High Alert Drugs (Antithrombotic agents)

<http://www.ismp.org/Tools/highalertmedications.pdf>

Joint Commission: Anticoagulant Sentinel Events

http://www.jointcommission.org/assets/1/18/SEA_41.PDF

Did You Know?

Near Miss Registry Impacting Graduate Medical Education in New York State

The NYACP Near Miss Patient Safety Training is now part of the mandatory training and core competency lecture for house staff at Winthrop University Hospital.

FACILITATOR: MICHAEL L. BAHN, BS, JD

Staff Attorney [Retired}
Medical Quality Assurance Commission
Department of Health

Mike was employed from April 1995 through December 2010 as a Staff Attorney for the Department of Health, serving the state's Medical Quality Assurance Commission. He performed the legal analysis and settlement of licensing and disciplinary cases generated by complaints of unprofessional conduct against medical doctors and physician assistants.

From August 1987 through March 1995 he was employed by the Department of Labor and Industries in the industrial safety and health division as the internal appeals hearings officer and administrative rules review officer.

Prior to working for the state, his law career began at the Spokane County Prosecutor's Office. Subsequently he entered private practice in Spokane specializing in contract, business, and employment law. He is a graduate of Gonzaga University School of Law, 1980, and the University of Wisconsin – Stevens Point, 1973.

Mike served the Washington State Bar Association's Administrative Law Section as its continuing legal education program coordinator. He is currently serving on the Bar Association's Disciplinary Board.

**Department Of Health
Medical Quality Assurance Commission
Washington State**

Policy/Procedure

Title:	Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery Through Consistent Discipline and Education	Number: MD2011-08
Contact:	Julie Kitten, Program Operations Manager	
Effective Date:		
Supersedes		
Approved		
	Leslie M. Burger, MD, FACP, Chair Medical Quality Assurance Commission	

BACKGROUND:

The Medical Quality Assurance Commission protects the health and safety of the citizens of Washington. Two of the principal ways the Commission protects the public is by taking disciplinary action against practitioners who fail to meet medical standards and by educating practitioners on appropriate medical standards.

The Commission recognizes a national effort to reduce medical errors, particularly wrong site, wrong procedure and wrong patient surgery. In 2003, The Joint Commission published The Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery.ⁱ These three events are the first three of the 29 “serious reportable events” identified by the National Quality Forum (NQF) as required to be reported.ⁱⁱ Since February 2009, the Centers for Medicare and Medicaid Services has not paid for any costs associated with wrong-site surgery. And many are familiar with the work of Atul Gawande, MD, who has shown the checklists can drastically reduce medical errors including wrong site, wrong procedure and wrong patient surgery.ⁱⁱⁱ

Washington law requires healthcare facilities to report sentinel events to the State of Washington Department of Health, which has implemented a quality improvement program designed to find the root cause of the event and ensure measures are taken to eliminate or reduce future medical errors.^{iv}

The Commission, in fulfilling its mission to protect the public and promote patient safety in the state of Washington, recognizes and supports the efforts of many entities in trying to reduce wrong site, wrong procedure and wrong patient

surgery. In 2008, the Commission adopted a policy requiring an investigation of a complaint involving wrong site, wrong procedure and wrong patient surgery.

Despite the efforts of the NQF, the Joint Commission, the Washington State Department of Health, and many others, wrong site, wrong procedure and wrong patient surgery still come to the attention of the Commission. And, although these events are not frequent, they can be devastating to the patient.^v

The Commission can assist in the reduction or elimination of wrong site, wrong procedure and wrong patient surgery. First, the Commission can take a consistent disciplinary approach to these cases. [Delete this sentence?] By imposing a standard set of sanctions in every event case, the Commission can help ensure that a physician does not repeat this event.

Second, the Commission can assist in educating the medical community about avoiding wrong site, wrong procedure and wrong patient surgery. The Commission believes that it will be particularly effective to require a physician who has had such an event to make presentations to educate physicians in his medical community or specialty about the event and the steps necessary to eliminate these events.

POLICY

The Commission will take a consistent approach to cases involving wrong site, wrong procedure and wrong patient surgery. In these cases, the Commission should impose sanctions designed to ensure the event will not re-occur, including a requirement for the physician to assist in educating the medical community to take steps to eliminate wrong site, wrong procedure and wrong patient surgery.

PROCEDURE:

1. A panel of the Commission reviews a file concerning wrong site, wrong procedure or wrong patient surgery.
2. The Commission panel votes to issue a Statement of Charges or offer Respondent a Stipulation to Informal Disposition, depending on the particular circumstances of the case.
3. The sanctions in the Order,^{vi} will comply with the sanctions schedule set forth in WAC 246-16-810. Wrong site, wrong procedure and wrong patient surgery will often fall into either tier B or C, depending on the level of harm to the patient. The sanctions may include the following:
 - A. A period of probation that is consistent with the applicable range of the sanction schedule.
 - B. The development of a written protocol for use in the facility in which

Respondent performs surgery. The protocol will incorporate and be consistent with the guidelines for preventing wrong site, wrong procedure and wrong patient surgery recommended by the Joint Commission, the American College of Surgeons or other appropriate national organization(s).

C. The preparation of a typed paper on the topic of wrong site, wrong procedure and wrong patient surgery, including how Respondent has implemented changes into his or her practice to prevent the event from re-occurring.

D. A requirement that the Respondent make a presentation on wrong site, wrong procedure and wrong patient surgery to a peer group at the facility in which Respondent has privileges.

E. A requirement that Respondent will report to the Commission wrong site, wrong procedure and wrong patient surgery that occurs during the effective term of the Order.

F. Respondent will permit a representative of the Commission to conduct periodic practice reviews for the primary purpose of verifying that Respondent is following surgical protocols designed to prevent wrong site, wrong procedure and wrong patient surgery.

G. Payment of a cost recovery or fine to the Commission.

ⁱ "Facts about the Universal Protocol,"

http://www.jointcommission.org/facts_about_the_universal_protocol/

ⁱⁱ National Quality Forum, "Serious Reportable Events: Transparency, Accountability critical to reducing medical errors and harm."

http://www.qualityforum.org/Publications/2008/10/Serious_Reportable_Events.aspx These events were initially called "never events," on the theory that they should never occur. However, with the addition of other events, the term was changed to "serious reportable events." <http://www.ama-assn.org/amednews/2011/06/27/prsa0627.htm>

ⁱⁱⁱ A. Gawande, *the Checklist Manifesto: How to Get Things Right*, (Metropolitan Books 2009); E. Cooney, "Surgical Checklist Passes Rigorous Test," Boston Globe (November 10, 2010)

http://www.boston.com/news/health/blog/2010/11/surgical_checkl_1.html

^{iv} RCW 70.56.

^v 71% of events reported to the Joint Commission over the past 12 years were fatal.

<http://psnet.ahrq.gov/primer.aspx?primerID=3>

^{vi} For the purposes of this policy/procedure, the term "order" includes a Stipulation to Informal

Disposition, a Stipulated Findings of Fact, Conclusions of Law and Agreed Order, and an order issued following a default or a waiver of hearing by Respondent, or a formal hearing.

RCW 18.71.002 Purpose.

It is the purpose of the medical quality assurance commission to regulate the competency and quality of professional health care providers under its jurisdiction by establishing, monitoring, and enforcing qualifications for licensing, consistent standards of practice, continuing competency mechanisms, and discipline. Rules, policies, and procedures developed by the commission must promote the delivery of quality health care to the residents of the state of Washington.

RCW 18.71.430 Pilot project — Commission — Authority over budget.

(1) The commission shall conduct a pilot project to evaluate the effect of granting the commission additional authority over budget development, spending, and staffing. The pilot project shall begin on July 1, 2008, and conclude on June 30, 2013.

(2) The pilot project shall include the following provisions:

(a) That the secretary shall employ an executive director that is:

(i) Hired by and serves at the pleasure of the commission;

(ii) Exempt from the provisions of the civil service law, chapter [41.06 RCW](#) and whose salary is established by the commission in accordance with [RCW 43.03.028](#) and [*42.17.370](#); and

(iii) Responsible for performing all administrative duties of the commission, including preparing an annual budget, and any other duties as delegated to the executive director by the commission;

(b) Consistent with the budgeting and accounting act:

(i) With regard to budget for the remainder of the 2007-2009 biennium, the commission has authority to spend the remaining funds allocated with respect to its professions, physicians regulated under this chapter and physician assistants regulated under chapter [18.71A RCW](#); and

(ii) Beginning with the 2009-2011 biennium, the commission is responsible for proposing its own biennial budget which the secretary must submit to the office of financial management;

(c) That, prior to adopting credentialing fees under [RCW 43.70.250](#), the secretary shall collaborate with the commission to determine the appropriate fees necessary to support the activities of the commission;

(d) That, prior to the secretary exercising the secretary's authority to adopt uniform rules and guidelines, or any other actions that might impact the licensing or disciplinary authority of the commission, the secretary shall first meet with the commission to determine how those rules or guidelines, or changes to rules or guidelines, might impact the commission's ability to effectively carry out its statutory duties. If the commission, in consultation with the secretary, determines that the proposed rules or guidelines, or changes to existing rules or guidelines, will negatively impact the commission's ability to effectively carry out its statutory duties, then the individual commission shall collaborate with the secretary to develop alternative solutions to mitigate the impacts. If an alternative solution cannot be reached, the parties may resolve the dispute through a mediator as set forth in (f) of this subsection;

(e) That the commission shall negotiate with the secretary to develop performance-based expectations, including identification of key performance measures. The performance expectations should focus on consistent, timely regulation of health care professionals; and

(f) That in the event there is a disagreement between the commission and the

secretary, that is unable to be resolved through negotiation, a representative of both parties shall agree on the designation of a third party to mediate the dispute.

(3) By December 15, 2013, the secretary, the commission, and the other commissions conducting similar pilot projects under RCW [18.79.390](#), [18.25.210](#), and [18.32.765](#), shall report to the governor and the legislature on the results of the pilot project. The report shall:

(a) Compare the effectiveness of licensing and disciplinary activities of each commission during the pilot project with the licensing and disciplinary activities of the commission prior to the pilot project and the disciplinary activities of other disciplining authorities during the same time period as the pilot project;

(b) Compare the efficiency of each commission with respect to the timeliness and personnel resources during the pilot project to the efficiency of the commission prior to the pilot project and the efficiency of other disciplining authorities during the same period as the pilot project;

(c) Compare the budgetary activity of each commission during the pilot project to the budgetary activity of the commission prior to the pilot project and to the budgetary activity of other disciplining authorities during the same period as the pilot project;

(d) Evaluate each commission's regulatory activities, including timelines, consistency of decision making, and performance levels in comparison to other disciplining authorities; and

(e) Review summaries of national research and data regarding regulatory effectiveness and patient safety.

(4) The secretary shall employ staff that are hired and managed by the executive director provided that nothing contained in this section may be construed to alter any existing collective bargaining unit or the provisions of any existing collective bargaining agreement.

RCW 18.130.020 Definitions. (9) "Practice review" means an investigative audit of records related to the complaint, without prior identification of specific patient or consumer names, or an assessment of the conditions, circumstances, and methods of the professional's practice related to the complaint, to determine whether unprofessional conduct may have been committed.

RCW 18.130.050 Authority of disciplining authority.

Except as provided in RCW [18.130.062](#), the disciplining authority has the following authority:

(1) To adopt, amend, and rescind such rules as are deemed necessary to carry out this chapter;

(2) To investigate all complaints or reports of unprofessional conduct as defined in this chapter;

(3) To hold hearings as provided in this chapter;

(4) To issue subpoenas and administer oaths in connection with any investigation, consideration of an application for license, hearing, or proceeding held under this chapter;

(5) To take or cause depositions to be taken and use other discovery procedures as needed in any investigation, hearing, or proceeding held under this chapter;

(6) To compel attendance of witnesses at hearings;

(7) In the course of investigating a complaint or report of unprofessional conduct, to

conduct practice reviews and to issue citations and assess fines for failure to produce documents, records, or other items in accordance with RCW [18.130.230](#);

(8) To take emergency action ordering summary suspension of a license, or restriction or limitation of the license holder's practice pending proceedings by the disciplining authority. Within fourteen days of a request by the affected license holder, the disciplining authority must provide a show cause hearing in accordance with the requirements of RCW [18.130.135](#). Consistent with RCW [18.130.370](#), a disciplining authority shall issue a summary suspension of the license or temporary practice permit of a license holder prohibited from practicing a health care profession in another state, federal, or foreign jurisdiction because of an act of unprofessional conduct that is substantially equivalent to an act of unprofessional conduct prohibited by this chapter or any of the chapters specified in RCW [18.130.040](#). The summary suspension remains in effect until proceedings by the Washington disciplining authority have been completed;

(9) To conduct show cause hearings in accordance with RCW [18.130.062](#) or [18.130.135](#) to review an action taken by the disciplining authority to suspend a license or restrict or limit a license holder's practice pending proceedings by the disciplining authority;

(10) To use a presiding officer as authorized in RCW [18.130.095](#)(3) or the office of administrative hearings as authorized in chapter [34.12](#) RCW to conduct hearings. The disciplining authority shall make the final decision regarding disposition of the license unless the disciplining authority elects to delegate in writing the final decision to the presiding officer. Disciplining authorities identified in RCW [18.130.040](#)(2)(b) may not delegate the final decision regarding disposition of the license or imposition of sanctions to a presiding officer in any case pertaining to standards of practice or where clinical expertise is necessary;

(11) To use individual members of the boards to direct investigations and to authorize the issuance of a citation under subsection (7) of this section. However, the member of the board shall not subsequently participate in the hearing of the case;

(12) To enter into contracts for professional services determined to be necessary for adequate enforcement of this chapter;

(13) To contract with license holders or other persons or organizations to provide services necessary for the monitoring and supervision of license holders who are placed on probation, whose professional activities are restricted, or who are for any authorized purpose subject to monitoring by the disciplining authority;

(14) To adopt standards of professional conduct or practice;

(15) To grant or deny license applications, and in the event of a finding of unprofessional conduct by an applicant or license holder, to impose any sanction against a license applicant or license holder provided by this chapter. After January 1, 2009, all sanctions must be issued in accordance with RCW [18.130.390](#);

(16) To restrict or place conditions on the practice of new licensees in order to protect the public and promote the safety of and confidence in the health care system;

(17) To designate individuals authorized to sign subpoenas and statements of charges;

(18) To establish panels consisting of three or more members of the board to perform any duty or authority within the board's jurisdiction under this chapter;

(19) To review and audit the records of licensed health facilities' or services' quality assurance committee decisions in which a license holder's practice privilege or employment is terminated or restricted. Each health facility or service shall produce and make accessible to the disciplining authority the appropriate records and otherwise

facilitate the review and audit. Information so gained shall not be subject to discovery or introduction into evidence in any civil action pursuant to RCW [70.41.200\(3\)](#).

RCW 18.130.065 Rules, policies, and orders — Secretary's role.

The secretary of health shall review and coordinate all proposed rules, interpretive statements, policy statements, and declaratory orders, as defined in chapter [34.05](#) RCW, that are proposed for adoption or issuance by any health profession board or commission vested with rule-making authority identified under RCW [18.130.040\(2\)\(b\)](#). The secretary shall review the proposed policy statements and declaratory orders against criteria that include the effect of the proposed rule, statement, or order upon existing health care policies and practice of health professionals. Within thirty days of the receipt of a proposed rule, interpretive statement, policy statement, or declaratory order from the originating board or commission, the secretary shall inform the board or commission of the results of the review, and shall provide any comments or suggestions that the secretary deems appropriate. Emergency rule making is not subject to this review process. The secretary is authorized to adopt rules and procedures for the coordination and review under this section.

RCW 18.130.070 Rules requiring reports — Court orders — Immunity from liability — Licensees required to report.

(1)(a) The secretary shall adopt rules requiring every license holder to report to the appropriate disciplining authority any conviction, determination, or finding that another license holder has committed an act which constitutes unprofessional conduct, or to report information to the disciplining authority, an impaired practitioner program, or voluntary substance abuse monitoring program approved by the disciplining authority, which indicates that the other license holder may not be able to practice his or her profession with reasonable skill and safety to consumers as a result of a mental or physical condition.

(b) The secretary may adopt rules to require other persons, including corporations, organizations, health care facilities, impaired practitioner programs, or voluntary substance abuse monitoring programs approved by a disciplining authority, and state or local government agencies to report:

(i) Any conviction, determination, or finding that a license holder has committed an act which constitutes unprofessional conduct; or

(ii) Information to the disciplining authority, an impaired practitioner program, or voluntary substance abuse monitoring program approved by the disciplining authority, which indicates that the license holder may not be able to practice his or her profession with reasonable skill and safety to consumers as a result of a mental or physical condition.

(c) If a report has been made by a hospital to the department pursuant to RCW [70.41.210](#) or by an ambulatory surgical facility pursuant to RCW [70.230.110](#), a report to the disciplining authority is not required. To facilitate meeting the intent of this section, the cooperation of agencies of the federal government is requested by reporting any conviction, determination, or finding that a federal employee or contractor regulated by the disciplining authorities enumerated in this chapter has committed an act which constituted unprofessional conduct and reporting any information which indicates that a federal employee or contractor regulated by the disciplining authorities enumerated in this chapter may not be able to practice his or her profession with reasonable skill and

safety as a result of a mental or physical condition.

(d) Reporting under this section is not required by:

(i) Any entity with a peer review committee, quality improvement committee or other similarly designated professional review committee, or by a license holder who is a member of such committee, during the investigative phase of the respective committee's operations if the investigation is completed in a timely manner; or

(ii) An impaired practitioner program or voluntary substance abuse monitoring program approved by a disciplining authority under RCW [18.130.175](#) if the license holder is currently enrolled in the treatment program, so long as the license holder actively participates in the treatment program and the license holder's impairment does not constitute a clear and present danger to the public health, safety, or welfare.

(2) If a person fails to furnish a required report, the disciplining authority may petition the superior court of the county in which the person resides or is found, and the court shall issue to the person an order to furnish the required report. A failure to obey the order is a contempt of court as provided in chapter [7.21](#) RCW.

(3) A person is immune from civil liability, whether direct or derivative, for providing information to the disciplining authority pursuant to the rules adopted under subsection (1) of this section.

(4)(a) The holder of a license subject to the jurisdiction of this chapter shall report to the disciplining authority:

(i) Any conviction, determination, or finding that he or she has committed unprofessional conduct or is unable to practice with reasonable skill or safety; and

(ii) Any disqualification from participation in the federal medicare program, under Title XVIII of the federal social security act or the federal medicaid program, under Title XIX of the federal social security act.

(b) Failure to report within thirty days of notice of the conviction, determination, finding, or disqualification constitutes grounds for disciplinary action.

RCW 18.130.160 Finding of unprofessional conduct — Orders — Sanctions — Stay — Costs — Stipulations.

Upon a finding, after hearing, that a license holder has committed unprofessional conduct or is unable to practice with reasonable skill and safety due to a physical or mental condition, the disciplining authority shall issue an order including sanctions adopted in accordance with the schedule adopted under RCW [18.130.390](#) giving proper consideration to any prior findings of fact under RCW [18.130.110](#), any stipulations to informal disposition under RCW [18.130.172](#), and any action taken by other in-state or out-of-state disciplining authorities. The order must provide for one or any combination of the following, as directed by the schedule:

(1) Revocation of the license;

(2) Suspension of the license for a fixed or indefinite term;

(3) Restriction or limitation of the practice;

(4) Requiring the satisfactory completion of a specific program of remedial education or treatment;

(5) The monitoring of the practice by a supervisor approved by the disciplining authority;

(6) Censure or reprimand;

(7) Compliance with conditions of probation for a designated period of time;

(8) Payment of a fine for each violation of this chapter, not to exceed five thousand dollars per violation. Funds received shall be placed in the health professions account;

- (9) Denial of the license request;
- (10) Corrective action;
- (11) Refund of fees billed to and collected from the consumer;
- (12) A surrender of the practitioner's license in lieu of other sanctions, which must be reported to the federal data bank.

Any of the actions under this section may be totally or partly stayed by the disciplining authority. Safeguarding the public's health and safety is the paramount responsibility of every disciplining authority. In determining what action is appropriate, the disciplining authority must consider the schedule adopted under RCW [18.130.390](#). Where the schedule allows flexibility in determining the appropriate sanction, the disciplining authority must first consider what sanctions are necessary to protect or compensate the public. Only after such provisions have been made may the disciplining authority consider and include in the order requirements designed to rehabilitate the license holder. All costs associated with compliance with orders issued under this section are the obligation of the license holder. The disciplining authority may order permanent revocation of a license if it finds that the license holder can never be rehabilitated or can never regain the ability to practice with reasonable skill and safety.

Surrender or permanent revocation of a license under this section is not subject to a petition for reinstatement under RCW [18.130.150](#).

The disciplining authority may determine that a case presents unique circumstances that the schedule adopted under RCW [18.130.390](#) does not adequately address. The disciplining authority may deviate from the schedule adopted under RCW [18.130.390](#) when selecting appropriate sanctions, but the disciplining authority must issue a written explanation of the basis for not following the schedule.

The license holder may enter into a stipulated disposition of charges that includes one or more of the sanctions of this section, but only after a statement of charges has been issued and the license holder has been afforded the opportunity for a hearing and has elected on the record to forego such a hearing. The stipulation shall either contain one or more specific findings of unprofessional conduct or inability to practice, or a statement by the license holder acknowledging that evidence is sufficient to justify one or more specified findings of unprofessional conduct or inability to practice. The stipulation entered into pursuant to this subsection shall be considered formal disciplinary action for all purposes.

RCW 18.130.175 Voluntary substance abuse monitoring programs.

(1) In lieu of disciplinary action under RCW [18.130.160](#) and if the disciplining authority determines that the unprofessional conduct may be the result of substance abuse, the disciplining authority may refer the license holder to a voluntary substance abuse monitoring program approved by the disciplining authority.

The cost of the treatment shall be the responsibility of the license holder, but the responsibility does not preclude payment by an employer, existing insurance coverage, or other sources. Primary alcoholism or other drug addiction treatment shall be provided by approved treatment programs under RCW [70.96A.020](#) or by any other provider approved by the entity or the commission. However, nothing shall prohibit the disciplining authority from approving additional services and programs as an adjunct to primary alcoholism or other drug addiction treatment. The disciplining authority may also approve the use of out-of-state programs. Referral of the license holder to the program shall be done only with the consent of the license holder. Referral to the program may

also include probationary conditions for a designated period of time. If the license holder does not consent to be referred to the program or does not successfully complete the program, the disciplining authority may take appropriate action under RCW [18.130.160](#) which includes suspension of the license unless or until the disciplining authority, in consultation with the director of the voluntary substance abuse monitoring program, determines the license holder is able to practice safely. The secretary shall adopt uniform rules for the evaluation by the disciplinary authority of a relapse or program violation on the part of a license holder in the substance abuse monitoring program. The evaluation shall encourage program participation with additional conditions, in lieu of disciplinary action, when the disciplinary authority determines that the license holder is able to continue to practice with reasonable skill and safety.

(2) In addition to approving substance abuse monitoring programs that may receive referrals from the disciplining authority, the disciplining authority may establish by rule requirements for participation of license holders who are not being investigated or monitored by the disciplining authority for substance abuse. License holders voluntarily participating in the approved programs without being referred by the disciplining authority shall not be subject to disciplinary action under RCW [18.130.160](#) for their substance abuse, and shall not have their participation made known to the disciplining authority, if they meet the requirements of this section and the program in which they are participating.

(3) The license holder shall sign a waiver allowing the program to release information to the disciplining authority if the licensee does not comply with the requirements of this section or is unable to practice with reasonable skill or safety. The substance abuse program shall report to the disciplining authority any license holder who fails to comply with the requirements of this section or the program or who, in the opinion of the program, is unable to practice with reasonable skill or safety. License holders shall report to the disciplining authority if they fail to comply with this section or do not complete the program's requirements. License holders may, upon the agreement of the program and disciplining authority, reenter the program if they have previously failed to comply with this section.

(4) The treatment and pretreatment records of license holders referred to or voluntarily participating in approved programs shall be confidential, shall be exempt from chapter [42.56](#) RCW, and shall not be subject to discovery by subpoena or admissible as evidence except for monitoring records reported to the disciplining authority for cause as defined in subsection (3) of this section. Monitoring records relating to license holders referred to the program by the disciplining authority or relating to license holders reported to the disciplining authority by the program for cause, shall be released to the disciplining authority at the request of the disciplining authority. Records held by the disciplining authority under this section shall be exempt from chapter [42.56](#) RCW and shall not be subject to discovery by subpoena except by the license holder.

(5) "Substance abuse," as used in this section, means the impairment, as determined by the disciplining authority, of a license holder's professional services by an addiction to, a dependency on, or the use of alcohol, legend drugs, or controlled substances.

(6) This section does not affect an employer's right or ability to make employment-related decisions regarding a license holder. This section does not restrict the authority of the disciplining authority to take disciplinary action for any other unprofessional conduct.

(7) A person who, in good faith, reports information or takes action in connection with this section is immune from civil liability for reporting information or taking the action.

(a) The immunity from civil liability provided by this section shall be liberally construed to accomplish the purposes of this section and the persons entitled to immunity shall include:

- (i) An approved monitoring treatment program;
- (ii) The professional association operating the program;
- (iii) Members, employees, or agents of the program or association;
- (iv) Persons reporting a license holder as being possibly impaired or providing information about the license holder's impairment; and
- (v) Professionals supervising or monitoring the course of the impaired license holder's treatment or rehabilitation.

(b) The courts are strongly encouraged to impose sanctions on clients and their attorneys whose allegations under this subsection are not made in good faith and are without either reasonable objective, substantive grounds, or both.

(c) The immunity provided in this section is in addition to any other immunity provided by law.

RCW 18.130.180 Unprofessional conduct. The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:

(1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgment and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the license holder of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purposes of this section, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter [9.96A](#) RCW;

(2) Misrepresentation or concealment of a material fact in obtaining a license or in reinstatement thereof;

(3) All advertising which is false, fraudulent, or misleading;

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

(5) Suspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction;

(6) Except when authorized by RCW [18.130.345](#), the possession, use, prescription for use, or distribution of controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diversion of controlled substances or legend drugs, the violation of any drug law, or prescribing controlled substances for oneself;

(7) Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care or professional conduct or practice;

(8) Failure to cooperate with the disciplining authority by:

(a) Not furnishing any papers, documents, records, or other items;

(b) Not furnishing in writing a full and complete explanation covering the matter contained in the complaint filed with the disciplining authority;

(c) Not responding to subpoenas issued by the disciplining authority, whether or not the recipient of the subpoena is the accused in the proceeding; or

(d) Not providing reasonable and timely access for authorized representatives of the disciplining authority seeking to perform practice reviews at facilities utilized by the license holder;

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

(10) Aiding or abetting an unlicensed person to practice when a license is required;

(11) Violations of rules established by any health agency;

(12) Practice beyond the scope of practice as defined by law or rule;

(13) Misrepresentation or fraud in any aspect of the conduct of the business or profession;

(14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk;

(15) Engaging in a profession involving contact with the public while suffering from a contagious or infectious disease involving serious risk to public health;

(16) Promotion for personal gain of any unnecessary or inefficacious drug, device, treatment, procedure, or service;

(17) Conviction of any gross misdemeanor or felony relating to the practice of the person's profession. For the purposes of this subsection, conviction includes all instances in which a plea of guilty or nolo contendere is the basis for conviction and all proceedings in which the sentence has been deferred or suspended. Nothing in this section abrogates rights guaranteed under chapter [9.96A](#) RCW;

(18) The procuring, or aiding or abetting in procuring, a criminal abortion;

(19) The offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the disciplining authority;

(20) The willful betrayal of a practitioner-patient privilege as recognized by law;

(21) Violation of chapter [19.68](#) RCW;

(22) Interference with an investigation or disciplinary proceeding by willful misrepresentation of facts before the disciplining authority or its authorized representative, or by the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action, or by the use of financial inducements to any patient or witness to prevent or attempt to prevent him or her from providing evidence in a disciplinary proceeding;

(23) Current misuse of:

(a) Alcohol;

(b) Controlled substances; or

(c) Legend drugs;

(24) Abuse of a client or patient or sexual contact with a client or patient;

(25) Acceptance of more than a nominal gratuity, hospitality, or subsidy offered by a

representative or vendor of medical or health-related products or services intended for patients, in contemplation of a sale or for use in research publishable in professional journals, where a conflict of interest is presented, as defined by rules of the disciplining authority, in consultation with the department, based on recognized professional ethical standards.

RCW 18.130.186 Voluntary substance abuse monitoring program — Content — License surcharge.

(1) To implement a substance abuse monitoring program for license holders specified under RCW [18.130.040](#), who are impaired by substance abuse, the disciplinary authority may enter into a contract with a voluntary substance abuse program under RCW [18.130.175](#). The program may include any or all of the following:

- (a) Contracting with providers of treatment programs;
- (b) Receiving and evaluating reports of suspected impairment from any source;
- (c) Intervening in cases of verified impairment;
- (d) Referring impaired license holders to treatment programs;
- (e) Monitoring the treatment and rehabilitation of impaired license holders including those ordered by the disciplinary authority;
- (f) Providing education, prevention of impairment, posttreatment monitoring, and support of rehabilitated impaired license holders; and
- (g) Performing other activities as agreed upon by the disciplinary authority.

(2) A contract entered into under subsection (1) of this section may be financed by a surcharge on each license issuance or renewal to be collected by the department of health from the license holders of the same regulated health profession. These moneys shall be placed in the health professions account to be used solely for the implementation of the program.

RCW 18.130.270 Continuing competency pilot projects.

The disciplinary authorities are authorized to develop and require licensees' participation in continuing competency pilot projects for the purpose of developing flexible, cost-efficient, effective, and geographically accessible competency assurance methods. The secretary shall establish criteria for development of pilot projects and shall select the disciplinary authorities that will participate from among the professions requesting participation. The department shall administer the projects in mutual cooperation with the disciplinary authority and shall allot and administer the budget for each pilot project. The department shall report to the legislature in January of each odd-numbered year concerning the progress and findings of the projects and shall make recommendations on the expansion of continued competency requirements to other licensed health professions.

Each disciplinary authority shall establish its pilot project in rule and may support the projects from a surcharge on each of the affected profession's license renewal in an amount established by the secretary. [1991 c 332 § 3.]

RCW 18.130.390 Sanctioning schedule — Development.

(1) Each of the disciplining authorities identified in RCW [18.130.040](#)(2)(b) shall appoint a representative to review the secretary's sanctioning guidelines, as well as guidelines adopted by any of the boards and

commissions, and collaborate to develop a schedule that defines appropriate ranges of sanctions that are applicable upon a determination that a license holder has committed unprofessional conduct as defined in this chapter or the chapters specified in RCW [18.130.040\(2\)](#). The schedule must identify aggravating and mitigating circumstances that may enhance or reduce the sanction imposed by the disciplining authority for unprofessional conduct. The schedule must apply to all disciplining authorities. In addition, the disciplining authorities shall make provisions for instances in which there are multiple findings of unprofessional conduct. When establishing the proposed schedule, the disciplining authorities shall consider maintaining consistent sanction determinations that maximize the protection of the public's health and while maintaining the rights of health care providers of the different health professions. The disciplining authorities shall submit the proposed schedule and recommendations to modify or adopt the secretary's guidelines to the secretary no later than November 15, 2008.

(2) The secretary shall adopt rules establishing a uniform sanctioning schedule that is consistent with the proposed schedule developed under subsection (1) of this section. The schedule shall be applied to all disciplinary actions commenced under this chapter after January 1, 2009. The secretary shall use his or her emergency rule-making authority pursuant to the procedures under chapter [34.05](#) RCW, to adopt rules that take effect no later than January 1, 2009, to implement the schedule.

(3) The disciplining authority may determine that a case presents unique circumstances that the schedule adopted under this section does not adequately address. The disciplining authority may deviate from the schedule adopted under this section when selecting appropriate sanctions, but the disciplining authority must issue a written explanation in the order of the basis for not following the schedule.

(4) The secretary shall report to the legislature by January 15, 2009, on the adoption of the sanctioning schedule.

WAC 246-919-640 Abuse. (1) A physician commits unprofessional conduct if the physician abuses a patient. A physician abuses a patient when he or she:

- (a) Makes statements regarding the patient's body, appearance, sexual history, or sexual orientation that have no legitimate medical or therapeutic purpose;
 - (b) Removes a patient's clothing or gown without consent;
 - (c) Fails to treat an unconscious or deceased patient's body or property respectfully;
- or

(d) Engages in any conduct, whether verbal or physical, which unreasonably demeans, humiliates, embarrasses, threatens, or harms a patient.

(2) A violation of any provision of this rule shall constitute grounds for disciplinary action.

