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PROTECTOR

Setting clinical risk management standards since 1913.

MEDICAL PROTECTIVE

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Dear Medical Protective healthcare provider:

In order to address the needs of the high-risk professional liability insurance market, Medical Protective last year began to offer a non-standard insurance policy,* known as E&S, which stands for Excess and Surplus Lines. This type of insurance is typically sold to provide coverage for individuals who can't obtain insurance within the industry's standard underwriting guidelines.

Who ends up in the E&S market – and why? How does the higher-risk status of this market impact the risk exposures of partners or colleagues? How do patients fit into this picture? This is the topic of this issue of *Protector.*

We'll explain why some physicians, dentists, and other healthcare providers turn to this market. We'll review risk factors commonly associated with the high-risk healthcare professional – including liability exposures that may inadvertently impact other members of the healthcare team. And, we'll review the duties that other members of the healthcare team may have in relationship to the at-risk behaviors of colleagues.

All healthcare providers need to be informed about non-standard insurance. While the individual doctor may never need E&S coverage, he or she may observe behaviors or actions of other providers that cause concern. Reluctance to respond to these concerns may place patients and other members of the healthcare team at risk. We'll review the obligations and options bystander colleagues may find helpful in dealing with these situations.

Please share your comments and suggestions.

Sincerely,

Kathleen M. Roman

Kathleen M. Roman
Editor

* Excess and surplus lines policies are underwritten by National Fire and Marine Insurance Company.

Disruptive Behavior:

An Overview and Recommendations for the Office-based Provider

Joyce Bruce, RN, MSN, JD, CPHRM

Maria was hired six months ago as the office manager for Greendale Family Practice where Dr. Stone has been in solo practice for many years and from which he plans to retire in the near future. Three months earlier, Dr. Hammer joined the practice. Maria has had many years of experience as an office manager but now she's at her wits' end. As she enters the office this morning she hears Dr. Hammer berating Sue, the new front desk associate.

"I can't believe you didn't reschedule these patients! What were you thinking?" "You'd better get this problem solved; I don't have time for these types of mistakes." Sue is visibly upset and after Dr. Hammer leaves, Maria attempts to talk with Sue, but it's too late. Sue tells Maria today will be her last day.

Not surprisingly, Sue is the third employee to resign because of Dr. Hammer's behavior since Maria joined the practice. Frustrated, Maria attempts to discuss the situation with Dr. Hammer but before she can complete a sentence, he barks, "What type of people are you hiring? Can't you hire anyone with a brain?" Before Maria can respond, Dr. Hammer hastily exits.

Reluctantly, Maria goes to Dr. Stone and reports that Dr. Hammer has run off yet another good employee. Dr. Stone listens and replies, "I'll talk to him later." Unfortunately, this has been Dr. Stone's reply every time she's voiced her concerns about Dr. Hammer's behavior. Because Dr. Stone has not actually witnessed Dr. Hammer's berating behavior, he is convinced that Maria may be exaggerating.

Is this disruptive behavior? If so, what can be done about it? By whom? How? And when?

What is Disruptive Behavior?

According to the AMA's *Code of Medical Ethics*, "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive [physician] behavior." (3)

Typically, disruptive physicians exhibit a pattern of these behaviors. Almost all healthcare providers have witnessed or been the recipient of disruptive behavior, which includes myriad behaviors that stem from a lack of respect. (31)

Verbal abuse may be exhibited as inappropriate language, yelling, gossiping, badgering, berating, sexual innuendos, criticism, or degrading and/or intimidating statements. Disruptive physical behavior can play out as ignoring others, physical boundary violations (getting right into someone's face), inappropriate touching and gestures, or throwing, pounding, or slamming objects. Certain individuals exhibit disruptive behavior through retaliation, failing to follow rules, or failing to carry out their duties.

Certainly, disruptive behavior is not limited to physicians but, since they generally work from a position of power within the healthcare system, their demands are more likely to have greater impact than those of other healthcare providers. And this impact, no matter how it is expressed, can have significant and sometimes catastrophic consequences, affecting many areas of the healthcare environment.

Disruptive physician behavior has been tolerated in medicine for centuries. As human rights have begun to play a more important role in civilized countries, the acceptance of disruptive behavior has eroded, interestingly, in parallel with society's rejection of sexual harassment. Significant efforts by leaders within the healthcare industry, professional organizations and accrediting agencies to address the problem of disruptive behavior have built a foundation for future progress. Yet, additional interventions and consistent efforts are needed to prevent and correct these issues.

The Impact of Disruptive Behavior

Staff Morale

The damage from disruptive behavior is multi-faceted but one of the most cited consequences is its negative impact on employee morale and job turnover. Staffers who experience verbal abuse experience feelings of low self-esteem and worthlessness. Disruptive behavior adversely affects staff morale, focus and concentration, collaboration, communication and information transfer – all of which can lead to substandard patient care. (3) In one study, nurses rated disruptive behavior as the single most negative influence on job satisfaction and morale, and 31 percent said they knew of at least one nurse who had resigned because of it. (39)

Patient Care

Consider these examples of the indirect impact disruptive behavior can have on patient care:

Case 1:
Carol, a Medical Assistant to Dr. Stevens, was aware that she had two patients with the same name; however, she failed to check for a second identifier and erroneously labeled a lab specimen. The error was found before the wrong patient received the results; however, Dr. Stevens, in an angry and threatening voice told Carol, "This had better never happen again!" Shortly thereafter, Carol was instructed to give an allergy shot to a patient. Distracted and upset, she chose the wrong patient vial – but didn't notice the error until after she had given the

injection. The patient suffered a severe anaphylactic reaction requiring transfer to the local hospital emergency department.

Case 2:
Dr. Jones and Dr. Kent have been in practice together for two years. For about the last six months, Dr. Kent has been "ill" on several occasions, necessitating rearrangement of the schedule and, on one occasion, the office manager called Dr. Jones at home because Dr. Kent was more than 30 minutes late for her first appointment and hadn't responded to repeated phone calls.

"Not surprisingly, seven percent of respondents said that they had been involved in a medication error caused by physician intimidation."

Staff noticed that Dr. Kent often appeared distracted and irritable. She had also been notified by the State Medical Board that a complaint had been filed relative to the quality of care she provided to her patients. Dr. Jones, concerned that Dr. Kent's behavior might jeopardize the practice, reviewed several of Dr. Kent's patients' charts and noted that Dr. Kent has failed to follow up on some significant patient lab results. Soon after, Dr. Kent and the corporation both doctors share, were named in a malpractice suit.

Patient Safety
A 2004 study by the Institute for Safe Medication Practices (ISMP) found that 49 percent of clinicians felt pressured to dispense or administer a drug despite their concerns about safety. And, 40 percent of these respondents kept quiet rather than confront the intimidating physician.

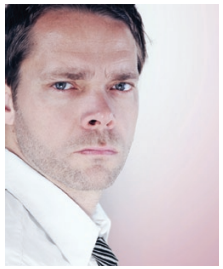
Not surprisingly, seven percent of respondents said that they had been involved in a medication error caused by physician intimidation. (23) Staff forced to deal with disruptive physicians learn to cope by avoidance and may thereby fail to timely communicate concerns and patient problems.

Failure to follow the rules is often part of a pattern of disruptive behavior, causing poor patient outcomes and medical error. Consider the 2002 Joint Commission National Patient Safety Goal for "Time-Out" and Universal Protocol. (6) While this standard set out requirements designed to reduce the incidence of wrong site surgery, in the ensuing time the incidence has actually increased. According to Dr. Dennis O'Leary, President of The Joint Commission in 2002, this increase should be attributed, in part, to surgeons who refuse to comply with preoperative time-out and surgical site marking requirements. These refusals result from the surgeon's resentment of a shift toward standardized procedures and the resultant loss of autonomy, O'Leary suggests. (35)

Patient Satisfaction
In many respects, it is patients who bear the brunt of disruptive physician behavior. A red flag for identifying disruptors can be linked to patient complaints. Frequently, complaints concerning physicians being rude, not returning calls, and not listening to the patient parallel the disruptive behavior experienced by staff and colleagues. Since patient complaints often escalate, these physicians also have a disproportionate share of malpractice claims. (21)

Financial Costs
Staff turnover is a multilayered loss to the organization. First, direct costs are incurred when the practice must pay overtime to remaining employees or obtain the services of temporary staff. Next, the practice must factor in replacement costs such as recruitment fees, credentialing and hiring processes, orientation, and work-start monitoring. Indirect costs include the loss of employee expertise that may not be recouped for several years. Productivity suffers as administrative time is required for "damage control" and remaining staff figure out workarounds. Rescheduling of patient appointments, procedures and treatments, patient transfers and complaints all take a financial toll.

Illustrative of the potential costs related to a physician's disruptive behavior towards staff, is the "workplace bullying" case, *Raess v. Doescher*, 858 N.E.2d 119 (Ind. Ct. App. 2006). In this case, Mr. Doescher, a perfusionist at a local hospital, filed suit against Dr. Raess, a cardiovascular surgeon, after he approached Mr. Doescher, angry that he had made reports to hospital administration about Dr. Raess's treatment of other perfusionists. Dr. Raess aggressively and rapidly approached Mr. Doescher with clenched fists, piercing eyes, beet-red face, popping veins, screaming and swearing at him. Dr. Raess further declared to Mr. Doescher, "You're finished, you're history!" Mr. Doescher sued Dr. Raess and a jury awarded him $325,000 on his claim for assault. This judgment was upheld by the Indiana Supreme Court. While this incident occurred in a hospital, actions like these from a disruptive physician can result in employment disputes and potentially criminal actions in the practice setting.



Unfortunately, the costs associated with staff turnover, poor patient outcomes and medical errors resulting in malpractice claims have a significant financial impact not only the physician involved, but also on the organizations and business entities with whom they are affiliated.

What Causes Disruptive Behavior?
It is difficult to pinpoint what may trigger disruptive behavior in physicians, but multiple causes have been suggested. Disruptive behavior is often assumed to be linked to drug or alcohol impairment but a survey by the American College of Physician Executives found that substance abuse contributes to less than ten percent of problematic physician behavior. Clearly, the problem is broader since it is estimated that half of all medical board complaints involving disruptive physicians are related not only to substance abuse but mental health issues such as depression, bipolar affective disorder, dementia, and delusional disorders.

More commonly, disruptive behavior is related to a belief by the physician of being above the rules and excused from the niceties of social etiquette. Offenders believe that they are members of a privileged class. (34) Physicians with characteristics of self-centeredness, immaturity, narcissism, or defensiveness are more likely to exhibit disruptive behavior and have poor interpersonal, coping, and conflict management skills. Compounding the problem is the educational model of autocratic and paternalistic behavior patterns that have been pervasive in medical school and residency training. (24) Stressful clinical environments and financial concerns from decreased reimbursements and pressure to increase volumes may also contribute to the problem.

Managing Disruptive Behavior

Identification and Confrontation

It is easy to identify overt disruptive behavior such as yelling or throwing items but covert behavior such as a pattern of ignoring phone calls or refusing to communicate with a partner can be just as problematic. Confrontation is a major challenge for staff and colleagues due to barriers that include:

- reluctance to confront ("It's not my problem.");
- fear of retaliation and retribution ("I need my job!");
- lack of confidential reporting systems ("They will know I'm the one who complained.");
- apathy ("Nothing ever changes!");
- cost ("Don't upset the rainmaker."); and
- acceptance of the disruptive behavior ("We just have to learn to deal with it.").

No matter what type of practice or organization, it is essential that physicians and leadership must be willing to confront disruptive behavior.

Code of Conduct

Codes of Conduct are the foundation to creating a culture intolerant of disruptive behavior. Codes of Conduct should embody a philosophy of respect and dignity but also be specific in identifying disruptive and inappropriate behavior necessitating action.

Though rarely seen in practice settings, Codes of Conduct and a framework for consequences should be incorporated into employment arrangements, partnership agreements and business contracts. It can be particularly uncomfortable for physicians who are partners to confront a disruptive partner. Enforcing behavior set out in a Code of Conduct ensures that any action taken is not seen as "personal" or unwarranted by the disruptor because it has already been set out in the arrangement.

"No matter what type of practice or organization, it is essential that physicians and leadership be willing to confront disruptive behavior."

The Framework

Whether in a policy or contract, a Code of Conduct that sets out both specific interpersonal and practice expectations is only as effective as the framework for managing disruptive behavior. Essentials should include:

- a clear mission to ensure a professional practice and workplace;
- a listing of the types of behavior that will trigger action;
- a process to document the behavior;
- identification of the person in the practice or organization who will receive the documentation;
- a process by which more than one individual, if possible, will review documentation of the incidents;
- a communication process to notify the physician with the alleged disruptive behavior and provide a mechanism for response;
- a tiered corrective action and evaluation process commensurate with the disruptive behavior;
- compliance monitoring; and
- confidentiality throughout the process.

Organizations and facilities may include Codes of Conduct and Disruptive Behavior policies in Medical Staff rules and regulations and enforce them as conditions for Medical Staff membership. Peer review policies should also be triggered for evaluation of disruptive behavior complaints.

Sports teams and other businesses have Codes of Conduct for image reasons and physician practices should, too. Patient complaints within the community, to professional organizations, and to consumer agencies can be detrimental to a practice's reputation and lead to financial loss. Negative publicity may also result from costly employment and malpractice claims stemming from disruptive behavior.

Remediation

Offering or referring the physician to organizations that provide counseling and support services should be part of the initial process for disruptive behavior management. Support should be coupled with a mutually agreed upon plan of counseling, practice reentry, and compliance monitoring goals. These goals often include continuing education, expectations of appropriate behavior, consequences for lack of compliance, and a mechanism for addressing future problems.

Resources include state Medical Boards, many of which have physician health programs, but other counseling and physician referral programs may also be appropriate.

Summary

The damage from disruptive physician behavior undermines every aspect of patient care. The historic culture of acceptance of disruptive behavior is being rejected; however, proactive strategies to prevent and address the problem have been slow to emerge. Disruptive physician behavior undermines the relationships, communication, and teamwork needed to provide quality patient care while creating patient safety issues, medical errors and dissatisfaction for both patients and staff. From a cost perspective, disruptive physician behavior spans every facet of practice from employee turnover costs, to coverage, duplication, patient volumes, medical error and substandard care.

Significant barriers continue to hamper efforts to resolve the problem of disruptive physician behavior. However, the stakes are too high for practices and organizations to ignore the behaviors that disruptive physicians exhibit. Every practice should take the opportunity to create a culture that facilitates quality patient care using the tools, processes, and strategies discussed. ■

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What to Look for: Signs of an At-Risk Colleague or Employee

It's true that sometimes hindsight is 20/20. Until you've experienced the stress and worry of working with a disruptive or impaired person, it's difficult to explain how that individual takes a toll on everyone else. Sometimes their behavior is manipulative and sometimes it's intimidating; in either case, their co-workers become embroiled in their drama and sometimes are the ones who are left to clean up the mess afterward.

What are the signs to watch for? Here are some indicators that a healthcare professional may be at risk of injuring a patient because of disruptive behaviors arising out of mental or physical health problems, including addiction, mental illness, cognitive impairment, physical ailments, or social maladjustment disorders.

Assessing the newcomer:

1. Has changed jobs frequently over the past several years, often with geographic relocations and unexplained periods of unemployment.
2. Several instances of having been employed in jobs that were inappropriate for his or her qualifications.
3. Makes excuses for not being able to produce appropriate or adequate references. Letters of reference are "vague" and don't really tell the story of the individual's accomplishments and skills. (20, 42)

Noting changes in a colleague:

1. Just not the person he or she used to be.
2. Makes inappropriate comments. Has become sarcastic, negative, antagonistic.
3. Complains of being misunderstood, overworked.
4. Deteriorated personal appearance, hygiene.
5. Seems physically shaky, nervous, sweaty.
6. Forgets commitments; arrives late; isn't prepared.
7. Withdraws from activities he or she was previously committed to: church, social activities, hobbies, etc. When participating in such activities, may behave inappropriately.
8. Has scrapes with the law, DUI citations, divorce proceedings, unexplained court dates. (20, 42, 44)

Can't be trusted at work:

1. Seems to have changed.
2. Is unreliable and unpredictable.
3. Makes inappropriate and/or unprofessional comments. Complains of being misunderstood, overworked.
4. Frequently absent, out sick, late. Irritable when pressed to improve.
5. Skips meetings; doesn't meet deadlines; staff begin to "doublecheck" on the individual's work in order to prevent errors.
6. Patients complain to staff. May have a history of disciplinary actions; may be involved in serial malpractice actions. (20)
7. Over-prescribes medicines. Orders excessive office supplies or drugs. Writes numerous prescriptions for personal use. (42, 44)

Awareness of these signs is part of the needed human resources plan for any organization, whether it be a huge health system or a small dental practice. Doctors who may be experiencing these types of actions need to recognize the possible signs of impairment in themselves so that they can obtain help. Those who work with them need to be able to help their co-workers and employees obtain needed help, to the extent possible – but in any event, to prevent possible injury to patients or other members of the medical or dental team.

Medical Protective Introduces E&S Coverage for Healthcare Providers in the Non-standard Market

Since 1899, Medical Protective has been at the forefront of professional liability insurance for healthcare professionals. Known for its strict underwriting stance, the company has a tradition of caution about the risks it has been willing to undertake in order to grow its book of business.

In the 1990s, the number of state-run joint underwriting associations (JUAs) has declined. Typically, these alternative insurance resources had provided insurance options for healthcare providers whose practice profiles fall outside the scope of standard lines insurers such as MedPro.

However, due to changes in the insurance industry, aggressive assistance programs within the healthcare professions, and updated state regulations, MedPro's leadership was convinced of the need for an alternative insurance resource for providers outside the standard market. In 2009, MedPro introduced its own E&S policy for healthcare providers, both individual or in group practices, whose risk characteristics place them outside standard admitted guidelines. Typically, these providers may have difficulty obtaining coverage due to claims, licensure limitations, or other unusual practice characteristics.

MedPro E&S accepts submissions in most states. Clients include physicians, dentists, and some other healthcare providers, who must annually seek coverage in the E&S market. As a service to those seeking coverage, providers who do not qualify for the company's admitted insurance product can now be referred to its E&S division for consideration, according to Mark Walthour, MedPro's senior vice president of underwriting. This flexibility provides a "one stop shop" option, Walthour says, and can help this segment of the market address their coverage challenges without the inconvenience of having to search for resources in a limited and highly selective marketplace. "Sometimes, when the wheels have fallen off because of stressful life events, the best thing about this type of insurance is the peace of mind it gives to the provider. These doctors have the assurance of coverage – and the comfort of knowing that they are with an organization that hopes they will be successful in reentering the standard market," Walthour said.

Healthcare providers who are covered under MedPro E&S will still enjoy the finest coverage available, Walthour says. Managed and administered by MedPro, MedPro E&S policies are written on National Fire and Marine paper, an excess and surplus lines company that is part of the Berkshire Hathaway group of businesses and maintains the highest A.M. Best rating of A++.

"These doctors have the assurance of coverage – and the comfort of knowing that they are with an organization that hopes they will be successful in reentering the standard market."

Healthcare providers insured by MedPro E&S through National Fire and Marine will also experience the same superior claims defense, financial stability, and industry-leading solutions as do all of MedPro insureds. Perhaps the greatest benefit to this arrangement is that, over time, consideration may be given for re-application to MedPro's admitted market product – and the associated reduction in premium.

Coverage terms and conditions for MedPro E&S clients vary and are determined during the application and underwriting process. ■

At-Risk Practitioners: A Danger to Patients and Themselves– And to Everyone Else in the Healthcare System

"I'm not impaired. I'm not disruptive. It's not my problem." Think again.

Kathleen M. Roman, M.S.

The times are changing!

It's been 12 years since the Institutes of Medicine (IOM) commanded national attention by insisting that patient safety is inextricably tied to the teamwork. (28) The days when one lone doctor was responsible for a patient's complete care are long gone. Successful outcomes in medicine and dentistry occur because numerous individuals work together on behalf of their patients. While the doctor may still be the traditional captain of the medical or dental "ship," the definition of captain has changed. Leadership, mentoring, collegiality, consultative professionalism – these terms are replacing the long-accepted role of dictator.

Increasingly, since the IOM reports, recent literature supports the contention that doctors who are unable to work well with others may be at greater risk of poor outcomes, higher rates of error, and greater incidences of malpractice litigation. (5, 17)

New accountabilities

According to the Joint Commission, "intimidating" and "disruptive behaviors" play havoc with the entire healthcare system. They have been tolerated for too long and "organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it."(6)

In 2009, the Joint Commission gave healthcare administrators greater clout in defining and measuring the acceptability of professional performance. LD.03.01.01 EP4 specifies that all hospitals and healthcare organizations should enact codes of conduct defining acceptable and inappropriate behaviors. In addition, LD.03.01.01 EP5 holds each organization's leadership accountable for the creation and implementation of policies and procedures designed to prevent/manage disruptive and inappropriate behaviors. (6) An organization that has such policies in place is generally better able to reign in doctors who are disruptive or dysfunctional.

"Doctors who can't make the connection to other members of the healthcare team find themselves increasingly ostracized."

Preventing harm, salvaging a career

Doctors may fall into this category for lots of reasons, according to Fred Frick, MD, medical consultant to the Physician Health Program of the Indiana Medical Society. "When things get out of hand, it helps if the hospital has a system in place that is fair and enforceable," Dr. Frick says. He notes that hospital administrators no longer knuckle under to the antics of a dysfunctional provider because he's bringing lots of patients into the system. He may also be driving money out of the system, Dr. Frick says, when other providers begin to refer their patients elsewhere, when such doctors harm the organization's reputation, drive away good staff, and increase the outlay for complaints and litigation.

Dr. Frick is also an internist specializing in diabetes care and endocrinology. He says that private medical practices – and by extension, dental practices – also need to have policies in place to help identify and manage at-risk providers. There are lots of reasons, he says, why physicians are referred to a state-offered program for providers. Speaking of the Indiana program, Dr. Frick noted several factors that may lead to a physician being referred. "A doctor may have a psychiatric disorder, such as depression or bi-polar disease. He may have a personality disorder such as disruptive behavior or anger management problems. Or he may have health issues, including physical pain or addiction."

The literature suggests that the prevalence of substance abuse in the healthcare professions is similar to that of the general population.(10, 11, 18) If this is so, then an average of 12 percent of physicians and dentists are impaired by drug or alcohol abuse at any time. Physicians who administer anesthesia – and some dentists, also find themselves in a higher risk category and suffer from higher recidivism rates. (32)

Doctors who can't make the connection to other members of the healthcare team find themselves increasingly ostracized, Dr. Frick says. More and more, the schools educating physicians, dentists, and nurses are teaching communication skills as a core competency. Over time, the content has advanced beyond "being nice to people," and introduced more process-oriented communication skills, such as dispute resolution, challenging inappropriate behavior, forcing policy/procedure compliance, etc. But Dr. Frick believes that, regardless of the environment of care, everyone on the team must be held accountable for their behavior. "An action plan needs to have due process built into it," he adds. "The individual needs to be sat down and made to understand that out-of-control behavior is a threat to patient safety, to the cohesiveness of the group, to the reputation of the organization, and to its ability to attract and retain highly competent staff and employees."

In his experience, Dr. Frick notes that "doctors who are pulled into reeducation programs are rarely happy to be there." But the threat of lost hospital privileges, financial penalties, disciplinary actions, etc., put some leverage into the process. In the Indiana program, 70-80 percent of doctors who are referred to this program "do make significant improvements in their ability to work well with other members of the healthcare team," Dr. Frick adds.

Silence as a risk factor

Hospitals may have professional leaders whose role it is to help deal with the problem of impaired or at-risk staff. Small groups and practices are unlikely to have this kind of skill set within their own ranks. The intimacy of size and the daily proximity to others increase the likelihood that some doctors and employees will overlook or ignore the inappropriate actions of impaired or disruptive individuals. They may believe that they are doing their colleague a favor, rationalizing that Dr. X "is having a tough time right now." Associates may

willingly engage in work arounds or take on additional responsibilities in order to compensate for the at-risk practitioner's actions. These accommodations aren't helpful; in fact, they are consistent with enabling the unacceptable behavior.

Staff and employees may feel that they have little choice if the person engaging in at-risk behaviors is in a position of authority. However, submissive behaviors may increase patient risk. "It's not my job to follow him around," a nurse may say. In tough economic times, many healthcare workers are fearful that they might lose their jobs if they rock the boat. Their feelings of frustration and helplessness increase stress, weaken morale, increase the likelihood of errors, and cause what is known as a toxic work environment.

Word does get out. Either a practice is seen as a respected employer or as a dysfunctional war zone. Groups who have even one disruptive or at-risk provider may find themselves in an administrative tailspin with: a) long-term, respected employees leaving; b) inability to attract equally qualified replacements; c) additional clinical staff turning down offers or current staff branching off on their own – thus becoming competitors; d) soaring administrative costs; and e) a significant increase in the number of patient complaints and patient transfers to other providers.

So, rather than looking the other way, practice-based physicians and dentists need to recognize that policies and procedures are all the more important in small practices since the negative impact of an out-of-control practitioner can have a more profound impact on the bottom line. These policies can often have a preventative effect and therefore should be in place *before* a provider gets too far afield. A review of these policies is essential as part of initial training for any new employee. They provide a framework for personal accountability and they support a culture of safety. Strategically, they allow the group's leaders to nip inappropriate behavior in the bud early on. Policies should also prevent retaliation against those who have reported dangerous behaviors. These protections for the individual who reports dangerous behaviors should take effect, regardless of the seniority or level of authority of either party. At this point, the commitment to patient safety is either a legitimate core value – or it's nothing more than a marketing slogan.

Don't look the other way.

A fair and equitable intervention program relies on its participants to be vigilant without being vigilantes. (For more information about signs of disruptive or at-risk behaviors, see *What to Look for…* on Pg. 10.) It relies on an active commitment to a culture of safety to protect patients, employees – and to the extent possible, assist the at-risk practitioner to come back into the fold. The healthcare professions are on board with these changes. Increasingly, codes of ethics require "step-up" behaviors from professionals who have witnessed inappropriate behaviors. The duty to report such actions is inherent in these professional obligations. (1, 2, 3, 4, 9, 13, 27, 33) The regulatory bodies expect to see improvements throughout the system. (6, 16, 41). From a risk management perspective, it can be more difficult to mount a staunch defense for a medical or dental practice that has been named in a malpractice lawsuit when it is clear that the administration and staff were actively compensating for a colleague's dangerous behaviors. ■

"The commitment to patient safety is either a legitimate core value – or it's nothing more than a marketing slogan."

Defending the Disruptive Or Impaired Provider:

High Stakes, High Loss, High Casualties

An examination of closed cases reveals that the out-of-control provider is often immersed in layers of liability. Their risky behaviors threaten their careers, friendships, family relationships, and financial stability. Beyond harming themselves, those close to them become the victims of their actions. These doctors increase the liability risks for colleagues, employees, and the corporate entity.

Other members of the medical or dental team should be adequately prepared to recognize and respond to disruptive or at-risk behaviors. They need training so that they understand the plan and are comfortable using it – before it ever becomes an issue. (See *What to Look for…* on Pg. 10.)

Following are some examples of Medical Protective cases in which physicians and dentists wreaked havoc within their professional and personal relationships. The purpose for sharing these cases is not to humiliate any reader who might recognize aspects of his or her own personality in these accounts. Rather, it is to encourage them, or those who work with them, to take action before it is too late. The Americans with Disabilities Act offers protections for those participating in certain types of recovery and treatment programs. No such protections will come into play if a patient, colleague, or employee is injured because of the reckless activities of an impaired or disruptive provider.

Case One:
The defendant in this case was a 53-year-old male, practicing family medicine. He was married and had children still living at home. The plaintiff was a 30-something female who came to his office with complaints related to ear, nose, and throat congestion. He also prescribed Zovirax for a herpes flare-up.

Shortly after she became his patient, they commenced a romantic relationship and began taking short "get-away" trips. He wrote "doctor notes" so that she would be excused from work and he paid the patient's expenses for these trips.

Over the next eight months, he wrote prescriptions for or gave her samples of: Anaprox, Bactrim, Cipro, Darvocet, Floricet, Foseal, Halcion, Nolex, Orthocyclen, Phenergan, Propo-N-100, Seldane, Slow Fe, Triphasal, Trisoral, and Vicodin.

After about eight months, the doctor sought to terminate the affair and as a result, the patient attempted to commit suicide – using drugs he had prescribed for her. Litigation ensued. It was during this time period that the defendant allegedly added the "no doctor-patient relationship" entry into the patient's record, according to the plaintiff's counsel.

Two years later, as the case was still in court, criminal charges were filed against this doctor alleging that he had had a 14-month sexual relationship with a different patient, a 15-year-old.

Shortly thereafter, the doctor committed suicide, leaving his widow and family facing a malpractice lawsuit that threatened to destroy them financially.

The jury returned a verdict in favor of the plaintiff. After numerous appeals and post-trial motions had been squelched by the state's supreme court, the plaintiff received $3.4 million, $1 million of which was assessed as punitive damages, a disciplinary penalty that typically is not covered by a professional liability insurance policy. Legal expense costs for this case exceeded $700,000.

Aside from the scandal and devastating impact on the defendant doctor's family, his medical practice was ruined. His partner, who had never treated the patient, became aware of the affair only after the patient's family called the practice to ask the defendant doctor to come to the hospital because the patient had attempted to commit suicide. The partner, whose name was on the practice, saw his name dragged through the mud and his practice dwindled even after he had split away from the existing corporation. His name was in the evening news off and on for nearly five years.

Out-of-control doctors leave a trail of victims, not all of whom are their patients.

Case Two:
A general practice dentist lost any chance of defending himself against an allegation that he anesthetized a female patient and sexually assaulted her during the course of a dental procedure when it was proven

that the patient was unconscious for nearly four hours – and none of the dental work that should have been completed during the appointment was done.

This doctor was very lucky in that the case was settled within his policy limits. He was also lucky in that he practiced in a state that did not automatically require a criminal investigation.

This same dentist had been named in an earlier sexual assault case but for personal reasons this plaintiff had eventually let the case drop.

*Of 10,001 actions naming **dentists**, 3454 (34.6 percent) could be categorized as disruptive and impaired.*

Disciplinary actions: National Practitioner Data Bank. 1991 – 2009.
National Practitioner Data Bank entries from 1991-2009.

Case Three:
When an impaired practitioner harms a patient, the chances of a successful defense seem to fly out the window. Like the drunk driver who kills an innocent victim, neither the courts nor public opinion are likely to forgive the damage caused by someone who suffers from the disease of addiction.

In the following case, an alcoholic pathologist misread an esophageal ulcer biopsy and diagnosed the patient as having esophogeal adenocarcinoma. As a result, the patient underwent removal of parts of his esophagus and stomach. The surgery precipitated a series of hospital errors that left the patient permanently disabled, both mentally and physically. Daily complications included his inability to take food except through a nasogastric tube and a significant risk of aspiration pneumonia.

The pathology report following the surgery denied any presence of cancer but by this time the hospital injuries had already occurred. Numerous factors seemed to conspire to derail this patient's life.

The pathologist took a leave of absence and entered his state medical society's recovery program. He completed the

*Of 37,321 actions naming **physicians**, 11,405 (31 percent) could be categorized as disruptive or impaired.*

National Practitioner Data Bank entries from 1991-2009.

program and did return to practice although he limited his work load and eliminated surgical pathology and cytology from his credentials.

Expert witnesses asked to review this case were highly critical of the pathologist's diagnosis of cancer. There was little clinical support for the error. This misinterpretation of this patient's biopsy spawned numerous additional lawsuits, against another radiologist, against three surgeons, and against the hospital and its nursing staff.

This lawsuit against the impaired pathologist was settled for $5 million.

The fact that this patient survived in enormously diminished capacity contributed to the significant assessment of economic damages and expenses that were taken into account when determining the day-to-day cost of managing his home care.

Other casualties:
To what extent did employees within this pathologist's office enable his behavior? How many people he worked with, either in his practice, or at the hospital, had concerns about his competence? What financial damage ensued within his office? What kinds of morale problems, staff turnover, other disciplinary oversights, etc., arose out of this negligent act?

According to a ten-year review of National Practitioner Data Bank information (12), 31 percent of reports involving physicians fall within the category of disruptive or impaired. As an example, Basis Codes list actions such as: a) narcotics violations, sexual misconduct, diversion of controlled substances, abusive conduct toward staff, etc.

Within the same time span, nearly 35 percent of reports involving dentists could be classified as arising out of disruptive or impaired behavior.

Every healthcare provider has a duty to protect patients and other practitioners from injury that may be caused by individuals who behavior is dangerous to others as well as to themselves. Regardless of the type of practice, physicians, dentists, and their staffs should have a plan to monitor and act on the signs of disruptive or impaired behavior. Failure to take action in light of these signs may signify the calm before the storm. ■

References and Suggested Reading

Since this issue of *Protector* focuses exclusively on the risks associated with identifying and managing the disruptive healthcare practitioner, this list may prove helpful for doctors and their staffs who want to know more about this difficult subject and develop or fine-tune their own system. For assistance with development of such a system, MedPro encourages its insureds to contact their risk management consultants.

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