Analyzing the Disruptive Physician: How State and Federal Courts Should Handle Whistleblower Cases Brought by Disruptive Physicians

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INTRODUCTION

The health care industry has become one of the most regulated industries in our country. Drastically increased government involvement in the past few decades has impacted all aspects of health care systems, from administrative operations to the daily activities of physicians. As a result, health care practitioners, especially physicians, are quicker to utilize the protections of this regulatory system to accomplish their own personal goals and protect their own personal interests. Furthermore, this increased regulation causes some physicians to grow more frustrated and angry, being confined by the walls of a legal system that they do not comprehend. These two problems have combined to give rise to the disruptive physician, the problem child of today's regulatory system.

The disruptive physician causes a plethora of pressures and dilemmas, both psychological and legal, in healthcare organizations. They can cause communications problems, decreased quality of care, interference with the orderly operations of the organization, and a vast amount of litigation. However, problems also arise when the physicians take their concerns with the organization's quality of care outside of the hospital to the Joint Commission on Accreditation of Healthcare Organization (hereinafter referred to as the JCAHO) or other government regulatory agencies. These external communications, coupled with the hospital's use of its internal disciplinary procedures, often avail the physician with the whistleblower defense when faced with a suspension or termination by the hospital.

2. Id. at 381.
3. Id. at 383. The majority of problems arise when the organization attempts to deal with the physician through the use of internal disciplinary procedures. Susan Lapenta, Disruptive Behavior and the Law, The Physician Executive Vol. 30, Issue 5, Pg. 24 (2004).
4. Springer & Casale, supra note 1, at 385.
In an attempt to provide a more workable test for handling disruptive physician cases, the following comment will compare how federal and state courts have handled cases brought by disruptive physicians claiming the whistleblower defense. Section I will define disruptive behavior. Section II will define whistle-blowing activity and its application to physician relations, as well as look at a recent editorial praising the whistleblower physician. Section III will look at the most applicable statute, the Health Care Quality Improvement Act (hereinafter referred to as the HCQIA). Section VI will compare cases upholding the hospitals' disciplinary actions with a case protecting the whistle-blowing physician. Finally, Section V will propose an amendment to the HCQIA, as well as a recommendation for the application thereof, that would simultaneously improve patient care and provide a more practicable approach for the legislature and state courts to address the issue.

I. DEFINING "DISRUPTIVE BEHAVIOR"

The American Medical Association (AMA) defines disruptive conduct as "[p]ersonal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care." The AMA further adds that disruptive conduct "includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.

The disruptive physician's troublesome personality often remains hidden, but emerges in situations where the physician is forced to work alongside other physicians or practitioners. A number of adjectives could be used to describe the disruptive physician, such as controlling, threatening, tenacious, and intimidating. However, when the typical activities of a disruptive physician are analyzed, a few patterns of behavior become evident. The typical disruptive physician believes himself to be more competent and caring than other practitioners. As a result, the content of a disruptive physician's comments and criticisms, while conveyed in a manner meant to intimidate or undermine, usually expresses

7. Id.
8. Springer & Casale, supra note 1, at 384.
9. Id. at 383.
10. Id.
concern for a patient. Thus, those who attempt to question or rebut a disruptive physician are viewed by the physician as ignorant, malicious, and lacking a concern for quality of care. This illustrates that most disruptive physicians are clever and charismatic, so as to be viewed by the media and the courts as sympathetic and caring, not threatening and intimidating.

Disruptive physicians usually manifest their emotions toward weaker, more vulnerable individuals because of their need to control. This typically takes the form of non-constructive criticism used to belittle and undermine confidence. There are also patterns of behavior that evidence a more subtle form of disruptive conduct, namely where the physician does not follow the rules or established lines of communication within the organization. Instead of voicing their concerns within the organization, disruptive physicians will take their complaints to the media, state or federal authorities, or the JCAHO. These public comments, both to the media and government regulatory agencies, permit the disruptive physician to raise the whistleblower defense when presented with disciplinary action by the hospital.

II. PHYSICIAN WHISTLEBLOWERS

Disruptive behavior often takes the form of ignoring established lines of communication within the healthcare organization and voicing complaints to state or federal authorities or the JCAHO. As stated above, when the hospital takes disciplinary action against the physician for his disruptive conduct, the physician will typically argue the statutory whistleblower defense. The defense

11. Id. at 386.
12. Id. at 384.
13. Springer & Casale, supra note 1, at 386.
14. Id.
15. Id.
16. Id. at 388.
17. Id.
19. Springer & Casale, supra note 1, at 388.
20. See, e.g., Clark, 25 P.3d at 221. The statutory whistleblower defense is set forth in 43 PA. CONS. STAT. § 1423, which states:

§ 1423. Protection of employees

(a) Persons not to be discharged.—No employer may discharge, threaten or otherwise discriminate or retaliate against an employee regarding the employee's compensation, terms, conditions, location or privileges of employment because the employee or a person acting on behalf of the employee makes a good faith report or is about to report, verbally or in writ-
is applicable in the majority of disruptive physician cases because of the statutory provision relating to the "privileges of employment." 21 In the majority of disruptive physician cases, the physician's clinical or medical staff privileges are suspended, revoked, or denied outright. 22

The whistleblower defense and its applicability to disruptive physicians have recently gained more public notability because of an October, 2003 exposé published by the Pittsburgh Post-Gazette. 23 The Post-Gazette ran a weeklong series titled, "Cost of Courage: How the Tables Turn on Doctors," which chronicled the stories of physicians who had brought forward quality of care concerns and been disciplined by their respective health care organizations in return. 24 The piece made the argument that physicians were being mislabeled with the "disruptive physician" tag and were actually whistleblowers trying to improve the quality of care. 25 The article used the results of two academic studies to support its contention. 26 The first, a 1998 survey of 448 emergency room physicians, found that twenty-three percent of the physicians either had lost a job or were threatened with firing after they raised quality of care concerns. 27 The second study, performed in 2001 by the University of Baltimore, found that whistleblower physicians who alienated hospital officials were more susceptible to having their hospital privileges taken away. 28

The four-part Post-Gazette series concluded with an article on the HCQIA and its harmful impact on physicians' abilities to le-

24. Id.
25. Id.
26. Id.
27. Id.
gally protect themselves. The piece made the argument that hospitals were using the HCQIA to shield themselves with immunity after taking retaliatory action against physician whistleblowers. Paul S. Blumenthal, an attorney in Annapolis, was quoted in the article as saying, "The Health Care Quality Improvement Act prevents doctors from actually trying to improve the medical system in which they work..."

III. THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

In 1986 Congress enacted the Health Care Quality Improvement Act to encourage hospital peer review activities "to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior." Accordingly, the HCQIA provides immunity for peer reviewers involved in taking professional review action based on competence or professional conduct. This statute establishes the requirements and standard of

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30. Id.
31. Id.
33. 42 U.S.C. § 11151(9) defines professional review action as an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.
§ 11111. Professional review.
(a) In general
(1) Limitation on damages for professional review actions
If a professional review action... of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section—
(A) the professional review body,
(B) any person acting as a member or staff to the body,
(C) any person under a contract or other formal agreement with the body, and
(D) any person who participates with or assists the body with respect to the action,
shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.
immunity for professional review actions and is applicable to disruptive physician cases, the majority of which involve action on the part of the hospital or health care organization's peer review committees.\textsuperscript{35} Every physician suspension or termination involves one, if not multiple, professional review committees of the hospital. Therefore, whether or not the standards set forth in HCQIA are met is extremely important to the ultimate disposition of the majority of disruptive physician cases.\textsuperscript{36}

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(2) Protection for those providing information to professional review bodies
Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

(b) Exception
If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 11133(a) of this title, the Secretary shall conduct an investigation.

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§ 11112. Standards for professional review actions
(a) In general
For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken—
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) 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
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts...

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A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.


IV. CASE LAW

In an attempt to determine whether courts in disruptive physician cases are more favorable toward physicians or hospitals, and which jurisdictions were more favorable than others, the author performed an extensive search for all recent court decisions involving physicians who challenged a hospital decision regarding appointment and clinical privileges based on the physician’s unprofessional or disruptive conduct. What this analysis will show is that courts of law have granted hospitals great deference in their handling of disruptive physician cases. The courts typically hold in favor of the hospital for one of three reasons: granting the hospital qualified immunity under HCQIA; granting deference to the hospital where it followed its own bylaws; or holding that disruptive behavior alone is a sufficient basis for the hospital to reprimand the physician. However, not all cases have been disposed of in favor of the hospital, as one recent case has upheld the application of the whistleblower defense to a disruptive physician.

A. Cases Upholding Hospital Action

As stated above, the vast majority of cases involving physicians who challenged a hospital decision regarding appointment and clinical privileges based on the physician’s unprofessional or disruptive conduct have been disposed of in favor of the hospital. However, courts have differed in their rationales for holding in favor of the hospital. The following sections discuss the three rationales most frequently applied by courts holding in favor of the hospital, illustrating which courts have applied each rationale and summarizing cases that best illustrate application of that rationale.

1. Qualified Immunity under HCQIA

The Health Care Quality Improvement Act provides immunity for members of hospital peer review committees involved in taking professional review action based on competence or professional

37. See, e.g., Bryan, 33 F.3d 1318; Gordon, 714 A.2d 539.
39. See, e.g., Leach, 870 F.2d 300; Ladenheim, 394 N.E.2d 770.
Being that the HCQIA is a federal statute, it is no surprise that the majority of cases applying this rationale have been decided in federal courts. However, the HCQIA makes clear that its contemplated immunity applies both to state and federal claims, and immunity has been granted by both state and federal courts.42

A good example of a local state court granting HCQIA immunity is the Pennsylvania Commonwealth Court case of Gordon v. Lewistown.43 That case involved a physician, Dr. Gordon, whose disruptive behavior took the form of berating and degrading a female nurse.44 After investigating the doctor's disruptive behavior, the hospital's credentials committee recommended that Dr. Gordon be suspended for twenty-eight days.45 In response, Dr. Gordon brought suit against the hospital seeking monetary damages for tortious interference with business relations, defamation, and breach of contract.46 The hospital filed a motion for summary judgment on all counts and sought monetary damages on the grounds that the hospital was immune from such claims under the Health Care Quality Improvement Act of 1986.47

In addressing the issue of immunity under the HCQIA, the court first established that, according to section 11112(a), the Act’s contemplated immunity applies both to state and federal claims.48 The court then stated that in order for the hospital to qualify for immunity from the claims for monetary damages, the four requisites of sections 11112(a)(1)-(4) must have been met.49 Therefore, the hospital’s action must have been taken: (1) in the reasonable belief that the action was in the furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures were afforded to the physician involved; and (4) in the reasonable belief that the action was warranted by the facts known.50 In first finding that the hospital’s action was in the furtherance of quality health care, the

44. Gordon, 714 A.2d at 540.
45. Id. This twenty-eight day suspension was subsequently affirmed by the hospital's appellate review panel. Id.
46. Id. at 540-41.
47. Id. at 540.
48. Id. at 541.
49. Gordon, 714 A.2d at 543.
50. Id.
court stated that disruptive behavior by a physician can be the basis of a hospital's belief that its actions were in the furtherance of quality health care.\textsuperscript{51} The court then held that the record was sufficient to find that the hospital made a reasonable effort to obtain the facts of the matter, provided reasonable notice and hearing procedures to Dr. Gordon, and took those actions under the belief that they were warranted by the facts then known.\textsuperscript{52} Therefore, the court held that Lewistown Hospital was immune from action for monetary damages by Dr. Gordon and granted the hospital's motion for summary judgment.\textsuperscript{53}

While \textit{Lewiston} is a good example of a state court dismissing a case in favor of a hospital on HCQIA grounds, HCQIA immunity is much more prevalent on the federal level.\textsuperscript{54} An example of this federal grant of immunity is the United States Court of Appeals, Eleventh Circuit, case of \textit{Bryan v. James E. Holmes Regional Medical Center}.\textsuperscript{55} That case involved a physician, Dr. Bryan, who had a reputation for being a "volcanic-tempered perfectionist," being extremely difficult to work with, and being critical and demeaning of his fellow co-workers.\textsuperscript{56} In response to this behavior, Holmes Regional Medical Center terminated Dr. Bryan's medical staff privileges.\textsuperscript{57}

Subsequent to his termination, Dr. Bryan brought suit against the hospital seeking monetary damages for violation of anti-trust laws, and a jury awarded him over four million dollars in damages.\textsuperscript{58} The hospital appealed the judgment, claiming that the trial court erred in not granting its motion for summary judgment on grounds of immunity under the HCQIA.\textsuperscript{59} The Eleventh Circuit first stated that HCQIA immunity presents solely an issue of law, which is to be determined by the trial court judge on motion and

\begin{itemize}
\item \textsuperscript{51} Id. at 544.
\item \textsuperscript{52} Id. at 544-48.
\item \textsuperscript{53} Id. at 549.
\item \textsuperscript{54} See, e.g., Freilich v. Upper Chesapeake Health, Inc., 313 F.3d 205 (4th Cir. 2002); Bryan v. James E. Holmes Regional Med. Cntr., 33 F.3d 1318 (11th Cir. 1994).
\item \textsuperscript{55} Bryan, 33 F.3d 1318 (11th Cir. 1994).
\item \textsuperscript{56} Bryan, 33 F.3d at 1324. Dr. Bryan was the subject of more than fifty written incident reports involving disruptive behavior. Id. at 1326.
\item \textsuperscript{57} Id. at 1324. The disciplinary process through which Dr. Bryan’s termination passed began with a suspension by the medical executive committee, followed by the recommendations for termination by multiple peer review committees, and ultimately a unanimous decision by the board of directors to terminate the physician’s medical staff privileges. Id. at 1327-28.
\item \textsuperscript{58} Id. at 1330-31.
\item \textsuperscript{59} Id. at 1332.
\end{itemize}
not by the jury. The court then addressed the issue of immunity under the HCQIA, applying the four-factor test set out in sections 11112(a)(1)-(4). The court found that the factual record supported a finding that all four factors were met. Therefore, the court held that the trial court erred in not entering judgment in favor of the hospital on grounds of immunity under the HCQIA.

2. Deference to Hospital Bylaws

A number of courts, in disposing of disruptive physician cases, have given deference to hospital disciplinary actions where the hospital's bylaws laid out a process for disciplining a disruptive physician and the hospital followed those bylaws in sanctioning the physician. The vast majority of courts applying this rationale have been state courts, with the exception of one federal district court.

The rationales adopted by the majority of state courts are all very similar to and exemplified by the Supreme Court of Appeals of West Virginia case of Mahmoodian v. United Hospital Center. In that case, an obstetrician's medical staff privileges were revoked due to a continuous pattern of disruptive and unprofessional behavior. United Hospital Center claimed that the physician's behavior was affecting the hospital's other physicians and obstetrical nurses and patients. In revoking the obstetrician's privileges, the hospital followed the procedure set out in its bylaws.

60. Id.
61. Bryan, 33 F.3d at 1334.
62. Id. at 1334-37. The court first found that the Hospital's actions were taken in the reasonable belief that the action was in the furtherance of quality health care because Dr. Bryan's presence in the operating room was interfering with the work of other employees. Id. at 1334. Secondly, the court held that the hospital board had made a reasonable effort to obtain the facts of the matter because the physician's conduct was evaluated by an executive committee, peer review panel, and by members of the board of directors. Id. at 1335. The hospital complied with notice requirements when it held hearings in a timely fashion in accordance with its bylaws. Id. at 1336. Finally, the court held that the facts of the case revealed that the board definitely had a factual basis for its action. Bryan, 33 F.3d at 1337.
63. Id. at 1337.
67. Mahmoodian, 404 S.E.2d at 752.
68. Id. at 753.
to handle disruptive physicians.\textsuperscript{69} This procedure began with an investigative committee that reported to the executive committee of the medical staff.\textsuperscript{70} The decision was then affirmed by an ad hoc hearing committee.\textsuperscript{71} In response, the obstetrician brought a civil action against the hospital seeking an injunction against the revocation of his medical staff privileges.\textsuperscript{72}

The main issue before the court of appeals was whether the revocation of the obstetrician’s privileges was subject to judicial review.\textsuperscript{73} Likening the issue to one of breach of contract, the Supreme Court of West Virginia first held that the issue was justiciable but only subject to limited judicial review to ensure that the hospital substantially complied with its medical staff bylaws.\textsuperscript{74} In addition, the court stated that a hospital may revoke or adversely affect an individual’s staff appointment or clinical privileges only if the medical staff bylaws provided a definite standard proscribing the conduct upon which the revocation was based.\textsuperscript{75} Furthermore, the court went on to state,

\begin{quote}
[A] hospital may adopt and enforce a medical staff bylaw providing that the disruptive conduct of a physician, in the sense of his or her inability to work in harmony with other health care personnel at the hospital, is grounds for denying, suspending, restricting, refusing to renew or revoking the staff appointment or clinical privileges of the offending physician, when such inability may have an adverse impact upon overall patient care at the hospital.\textsuperscript{76}
\end{quote}

Applying these rules to the present case, the court held that United Hospital Center’s medical staff bylaws provided a reasonably definite standard of disruptive conduct, detailing what was expected of members of its medical staff. Furthermore, the court held that these standards had been correctly applied by the hospital to the obstetrician’s disruptive conduct in this case.\textsuperscript{77}

\textsuperscript{69} Id. at 753-54.  
\textsuperscript{70} Id. at 753.  
\textsuperscript{71} Id. at 754.  
\textsuperscript{72} Mahmoodian, 404 S.E.2d at 754.  
\textsuperscript{73} Id. at 755. The court also addressed the issue of the applicable scope of review in a disruptive physician case. Id.  
\textsuperscript{74} Id.  
\textsuperscript{75} Id. at 758.  
\textsuperscript{76} Id. at 760.  
\textsuperscript{77} Mahmoodian, 404 S.E.2d at 762.
The one federal court case that adopted the deference to bylaws rationale was the United States District Court for the Middle District of Pennsylvania decision of *Hoberman v. Lock Haven Hospital.*\(^7^8\) This case involved a physician, Dr. Hoberman, whose disruptive conduct included the coercion and harassment of other members of the medical staff who did not refer all of their cases to him, and other various extreme emotional outbursts throughout the hospital.\(^7^9\) The hospital bylaws provided that physicians charged with unethical conduct should be given notice and an opportunity to appear before the committee, but they did not provide a right to cross-examine.\(^8^0\) As a result of the closed session, the executive committee found Dr. Hoberman guilty of breaches of conduct incompatible with acceptable professional behavior and quality health care.\(^8^1\)

In response to the findings of the executive committee, Dr. Hoberman brought suit in federal district court, alleging state and federal causes of action for breach of contract.\(^8^2\) Addressing these claims, the district court first stated that the relationship of a hospital and a member of its medical staff is basically one of contract, and the medical staff bylaws form part of that contract.\(^8^3\) Therefore, where the bylaws provide a member of the medical staff with rights to a hearing prior to termination or suspension of his privileges, such hearing must be provided, or the physician would have a cause of action for breach of contract.\(^8^4\) However, in the present case the bylaws provided that the physician was entitled to be present at the hearing, but said nothing of a right to cross-examine witnesses.\(^8^5\) Therefore, according to the court, the plaintiff was not deprived of any rights conferred upon him by the bylaws, and thus he could not bring a cause of action for breach of contract.\(^8^6\) The hospital had not breached the contract because it

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79. *Hoberman,* 377 F. Supp. at 1181. Another member of the medical staff filed formal charges of unethical practices against Dr. Hoberman. *Id.* In response to these charges, the medical staff executive committee met in a closed session to investigate and discuss the charges. *Id.* Dr. Hoberman was given an opportunity to attend this meeting, but was not provided with an opportunity to confront and cross-examine witnesses testifying at the meeting against him. *Id.*
80. *Id.* at 1182.
81. *Id.* at 1181-82.
82. *Id.* at 1183.
83. *Id.* at 1189.
85. *Id.*
86. *Id.* at 1190.
had followed the procedure set out in its bylaws.\textsuperscript{87} Therefore, Dr. Hoberman's state cause of action for breach of contract against the hospital was dismissed.\textsuperscript{88}

3. Disruptive Behavior Sufficient

Multiple federal jurisdictions have established a duty on the part of the hospital to intervene and take action where a physician is disruptive and extremely unprofessional.\textsuperscript{89} In line with this rule, a number of federal and state courts have held that disruptive conduct alone provides a sufficient basis for a hospital decision regarding appointment and clinical privileges based on the physician's unprofessional or disruptive conduct.\textsuperscript{90} While it was a federal court that first advanced and applied the hospital duty to intervene, the above breakdown illustrates that state courts have followed suit in holding disruptive behavior a sufficient grounds for hospital disciplinary action.

The United States Court of Appeals, Fifth Circuit, case of \textit{Leach v. Jefferson Parish Hospital District}\textsuperscript{91} was one of the first cases to establish the duty of a hospital to intervene where a physician's disruptive behavior was affecting the hospital's quality of care. That case involved Dr. Richard Leach, whose physician privileges were summarily suspended for one year by East Jefferson Hospital in response to Dr. Leach's disruptive behavior.\textsuperscript{92} The hospital informed Dr. Leach that he could reapply for appointment to the medical staff after one year, but the doctor instead chose to sue the hospital for deprivation of due process and equal protection rights.\textsuperscript{93} In addressing the doctor's constitutional claims, the circuit court emphasized that a hospital has a clear duty and interest in providing quality health care to its patients.\textsuperscript{94} Therefore, if a physician is disruptive or has behavioral problems, the hospital has a duty to intervene to maintain a high quality of care.\textsuperscript{95}

\begin{itemize}
\item \textsuperscript{87} \textit{Id.}
\item \textsuperscript{88} \textit{Id.}
\item \textsuperscript{89} See, e.g., \textit{Leach v. Jefferson Parish Hosp. Dist.}, 870 F.2d 300 (5th Cir. 1989); Robbins v. Ong, 452 F. Supp. 110 (S.D. Ga. 1978).
\item \textsuperscript{91} 870 F.2d 300 (5th Cir. 1989).
\item \textsuperscript{92} \textit{Leach}, 870 F.2d at 301.
\item \textsuperscript{93} \textit{Id.} at 302.
\item \textsuperscript{94} \textit{Id.}
\item \textsuperscript{95} \textit{Id.}
\end{itemize}
this reasoning in mind, the court held that the hospital's duty to maintain quality health care far outweighs the burden on a physician, in this case Dr. Leach, to reapply for staff privileges.\textsuperscript{96} Therefore, the Fifth Circuit dismissed Dr. Leach's due process and equal protection claims.\textsuperscript{97}

Along the same lines with the hospital's duty to intervene, a number of courts have held that disruptive behavior alone provides a sufficient basis for a hospital's decision regarding a physician's privileges.\textsuperscript{98} This rule is evidenced in the Appellate Court of Illinois case of Ladenheim \textit{v. Union County Hospital District.}\textsuperscript{99} That case involved a physician, Dr. Ladenheim, whose application for reappointment to Union County Hospital was rejected because of his previous disruptive conduct.\textsuperscript{100}

Subsequent to the disapproval of his application, Dr. Ladenheim brought suit seeking an injunction against the hospital that would require it to approve his application for medical staff privileges.\textsuperscript{101} Dr. Ladenheim specifically contended that the findings of the credentials committee were against the weight of evidence.\textsuperscript{102} The Illinois Appellate Court stated that the record was replete with evidence of Dr. Ladenheim's inability to work with other members of the hospital staff.\textsuperscript{103} The court then stated its belief that the ability of a physician to work smoothly with others on the hospital staff is reasonably related to the hospital's objective of providing quality care.\textsuperscript{104} In addition, an individual's inability to work well with others on the medical staff is sufficient grounds to deny that individual medical staff privileges.\textsuperscript{105} Therefore, the appellate

\textsuperscript{96} Id. at 303.
\textsuperscript{97} \textit{Leach}, 870 F.2d at 303.
\textsuperscript{100} \textit{Lademheim}, 394 N.E.2d at 772. The physician was charged with sixteen counts of unprofessional conduct, including demeaning comments and behavior toward physical therapists, nurses, office staff, and patients. \textit{Id.} In response to Dr. Ladenheim's appeal, a hearing was conducted before the executive committee of the medical staff, which found all of the charges against the physician to be true and affirmed the rejection of his application. \textit{Id.}
\textsuperscript{101} Id. at 773.
\textsuperscript{102} Id. at 775.
\textsuperscript{103} \textit{Id.}
\textsuperscript{104} \textit{Id.}
\textsuperscript{105} \textit{Lademheim}, 394 N.E.2d at 776.
court affirmed the lower court's decision to uphold Union County Hospital's denial of staff privileges to Dr. Ladenheim.¹⁰⁶

B. Case Protecting the Whistleblower

As strong as the immunity of the HCQIA is, and as expansive as the case law in support of hospitals is, these protections are not absolute. One of the main requirements of the HCQIA is that the action by the hospital must have been taken under the reasonable belief that it was in the furtherance of quality health care.¹⁰⁷ If this requirement is not met, and if the physician's disruptive conduct has manifested itself in the form of external communications to government agencies, the door is open for the physician to successfully claim the whistleblower defense in response to the hospital's disciplinary action. This was the case in the Nevada Supreme Court decision of Clark v. Columbia/HCA Information Services.¹⁰⁸

Clark involved a psychiatrist, Dr. Kenneth M. Clark, who had intermittent appointment and clinical privileges at Truckee Meadows Hospital from 1981 to 1993.¹⁰⁹ In September 1992, the hospital alleged that Dr. Clark was engaging in disruptive conduct in violation of medical staff bylaws and informed him that it would hold a peer review hearing concerning his conduct.¹¹⁰ The statement of charges against Dr. Clark included: that he wrote letters to CHAMPUS (a federal insurance provider) and the JCAHO regarding medical staff policy and quality of care issues; that he failed to abide by his agreement with the hospital to work internally to settle his grievances; that he made an August 1992 report to the Nevada State Board of Medical Examiners containing false allegations; and that he was allegedly doing rounds when he had no patients.¹¹¹ The peer review hearing committee concluded that Dr. Clark's behavior constituted disruptive conduct in violation of medical staff bylaws and unanimously recommended revoking Dr. Clark's appointment and clinical privileges.¹¹²

¹⁰⁶. Id.
¹⁰⁹. Clark, 25 P.3d at 218.
¹¹⁰. Id.
¹¹¹. Id.
¹¹². Id. at 219. This determination was subsequently affirmed by the Medical Executive Committee and the Board of Trustees. Id.
After unsuccessfully filing suit against the hospital in federal court, Dr. Clark brought suit in Nevada state court, alleging that the hospital conspired to commit illegal conduct and improperly terminated his staff privileges. The hospital filed a motion to dismiss under HCQIA, and the motion was granted. Dr. Clark then appealed to the Supreme Court of Nevada, arguing that the HCQIA was not applicable because the revocation of his privileges was not made with the reasonable belief that it was in furtherance of quality health care.

The state supreme court, in addressing the issue of immunity, first pointed out that the presumption in cases such as this is almost exclusively in favor of granting immunity for peer review board members. The court then distinguished this case from previous cases upholding the presumption, stating that the findings of the hospital indicate that the reason for Dr. Clark’s dismissal was his reports to outside agencies. The court went on to specifically state that “[r]evoking Clark’s privileges based on this whistleblowing activity does not objectively further quality health care under § 11112(a)(1); thus, respondents are not entitled to immunity as a matter of law for their decision to revoke Clark’s staff privileges.” Therefore, the court held that Dr. Clark had overcome the presumption of immunity and thus the hospital was not entitled to qualified immunity under the HCQIA.

This case, while in the extreme minority, illustrates that HCQIA immunity and adherence to hospital bylaws do not provide absolute protection from lawsuits brought in response to a hospital’s disciplinary action against a disruptive physician. The hospital’s objective must be the furtherance of quality care and its decision must not be made directly in response to whistle-blowing activity for the hospital to be protected from a physician’s suit.

V. UNIVERSAL APPLICATION OF AMENDED HCQIA

The above analysis illustrates that the HCQIA has been successful in all of the cases surveyed but one in protecting the hospital from disruptive physicians claiming whistleblower status.

113. Id. at 219.
115. Id. at 220.
116. Id. at 222.
117. Id.
118. Id.
119. Clark, 25 P.3d at 223.
However, the protections the statute provides for hospitals could be strengthened if it were amended to effectuate the contractual nature of the physician-hospital relationship. Furthermore, I would urge all state legislatures or the highest state courts to adopt my amended HCQIA as the law of their state, as this universal adoption would lead to more collegial health care relationships, and in turn an increase in quality health care.

In order to realistically reflect the contractual nature of the physician-hospital relationship, the HCQIA should be amended in two places to contain provisions in relation to medical staff bylaws. As illustrated above, in both Mahmoodian and Hoberman, courts have given deference to hospital disciplinary action where the hospital followed procedures laid out in its medical staff bylaws. In granting this deference, the courts have held the medical staff bylaws to be part of the physician contract. In order to effectuate this contractual analysis, I would first amend the four-part test for professional review actions provided in 42 U.S.C. § 11112(a). The third part of that test requires that “a professional review action must be taken — ....(3) 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.” I would amend this test to require the hospital to comply with its bylaws, and it would read “a professional review action must be taken — . . . (3) after adequate notice and hearing procedures provided for in the medical staff bylaws (if so available) are afforded to the physician involved.”

While the above change might be sufficient to adequately protect the contractual nature of the relationship, I would also add a safe harbor provision to section 11112 that would be consistent with the court opinions in Mahmoodian and Hoberman. I would place this safe harbor at the end of section 11112 as provision (d). The safe harbor would read:

(d) Equitable procedures provided for in bylaws — Absent a showing of bad faith or malicious intent, a hospital review action shall be presumed to have met the standards for protection set out in sections 11111(a) and 11112(a) if

121. Mahmoodian, 404 S.E.2d at 755.
it follows equitable disciplinary procedures provided for in its medical staff bylaws.

This language would effectuate the statement by the Mahmoodian court that “a hospital may adopt and enforce a medical staff bylaw providing that the disruptive conduct of a physician . . . is grounds for denying, suspending, restricting, refusing, or revoking the staff appointment or clinical privileges of the offending physician.”

The amendments to the HCQIA provided above would greatly change the landscape of the physician-hospital relationship. The goal of any health care organizational relationship should be the improvement of quality care. Quality care is just as much the result of effective collegial communication among physicians and administrators as it is of the requisite skill level of the physicians on the medical staff. However, with the growing impact of disruptive physicians, today’s health care system and its success in providing quality care is unfortunately too reliant on adversary relationships. The amendments proposed above would greatly strengthen the presumption in favor of the hospital and, in turn, would force the physicians to better utilize internal lines of communication. This is so because, as long as the hospital follows equitable provisions provided for in its bylaws, a hospital can discipline a physician for not following the established lines of communication within the organization. This increased use of internal lines of communication would in turn lead to a more collegial atmosphere among physicians and health care administrators.

At the same time, the above amendments would not leave a physician without recourse in the case of wrongdoing. If the hospital does not contain disciplinary provisions in its bylaws, the four-part test of 11112(a) is still applicable and the hospital will not be protected where the prerequisites of that test are not met. Furthermore, if the hospital does not follow the provisions laid out in its bylaws, the safe harbor will not be applicable and the amended four-part test of 11112(a) will likely not be met. In addition, if the hospital, in following through with the disciplinary provisions of its bylaws, does so in bad faith, then it will not be provided the protections of the safe harbor. Again, this provision is in line with a contractual analysis, as parties to a contract are not typically provided the benefit of that contract where they bargained or acted in bad faith regarding the contract.

123. Mahmoodian, 404 S.E.2d at 760.
In order to truly empower the amended HCQIA to improve quality care nationwide, it would be my goal that all states, either through their legislature or highest court, adopt the amended HCQIA as the law of their state. The strong presumption discussed above would only have its effect on physician behavior if the physicians knew that their state court would apply the amended test and safe harbor. Furthermore, today’s top physicians are often subject to immense recruitment and, as a result, relocate to different hospitals in different states. If a physician were to move from one state that adopted the amended HCQIA to another that did not, it might lead to confusion on the part of the physician regarding the law, and, in turn, to the use of external lines of communication with state organizations. Therefore, I would urge as many states as possible to adopt the amended HCQIA as the law of their state to effectuate the goal of improvement in nationwide quality care.

When analyzed under the above changes to the HCQIA, the Nevada Supreme Court case of Clark v. Columbia/HCA Information Services was correctly decided. According to the recitation of the facts in the case, the hospital involved, Truckee Meadows Hospital, did not have medical staff bylaws that provided disciplinary procedures. Therefore, under the amended HCQIA, the issue of immunity would be decided by applying the four part test laid out in section 11112(a). That is exactly what the court did in Clark, and it found that prong one of the test, requiring that the hospital action be in the furtherance of quality health care, was not met. This first prong of the four-part test would remain unchanged under my amended HCQIA, and therefore the case was correctly decided. Many attorneys and health care scholars may attempt to distinguish Clark from the other disruptive physician cases. However, in making such an argument, they would fail to realize that Clark is a perfect example of how a case should be decided by a state court, through application of the provisions of the Health Care Quality Improvement Act. Clark is an example of how the system should work to protect the physician, the hospital, and especially quality care.

126. Clark, 25 P.3d at 218.
127. Id. at 222.
VI. CONCLUSION

Disruptive physicians can cause a number of problems in a health care system, including communication problems, interference with the orderly operations of the organization, a vast amount of litigation, and a decrease in the quality of care.\(^{128}\) It is this last effect, a decrease in the quality of care, which has proven to be the deciding factor in the vast majority of cases dealing with disruptive physicians. As the above analysis illustrates, courts in almost every jurisdiction in America have disposed of disruptive physician cases in favor of the hospital. They have done so for a number of reasons, granting qualified immunity under HCQIA;\(^{129}\) giving deference to the hospital where it followed its own bylaws;\(^{130}\) and holding that disruptive behavior alone is a sufficient basis for the hospital to reprimand the physician.\(^{131}\) While these three rationales may stand on three completely different legal spectrums, every court applying them had one common goal in mind: the maintenance and expansion of quality healthcare in America’s hospitals.

Some individuals in the public sector or the media have attempted, and may in the future attempt, to portray disruptive physicians as courageous whistleblowers, speaking out against the establishment to protect patients.\(^{132}\) However, as the case law illustrates, this is just not the situation. Therefore, in order to increase collegial communication within healthcare organizations, and to minimize the external impact of disruptive physicians, I propose two amendments be made to the HCQIA. These amendments would provide hospitals with a stronger presumption of validity in their actions where they follow disciplinary provisions provided for in their bylaws. Disruptive physicians decrease the quality of health care provided in America’s hospitals, and their chance of success under my amended HCQIA would be about as positive as their attitudes toward their fellow co-workers.

Zachary L. Erwin

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128. Springer & Casale, supra note 1, at 383.
132. Twedt, supra note 23.