

January 17, 2007

**Jointly Adopted Comments to the Proposed Hospital Disruptive
Behavior JCAHO Leadership Standard**

Jointly approved and submitted by:

- 1) The Association of American Physicians and Surgeons, Inc. and
- 2) The Semmelweis Society International, Inc.

Background:

The Association of American Physicians & Surgeons, Inc. (“AAPS”) is a non-profit national organization consisting of thousands of physicians in all specialties. Founded in 1943, AAPS is dedicated to defending the patient-physician relationship and the ethical practice of medicine. AAPS is one of the largest physician organizations funded virtually entirely by its physician membership. This enables it to speak directly on behalf of the ethical service of patients who entrust their care to the medical profession. The motto of AAPS is “omnia pro aegroto,” or “all for the patient.” In 2006, the Third Circuit cited an AAPS amicus brief in the first paragraph of the decision. *Springer v. Henry*, 435 F.3d 268, 271 (3d Cir. 2006). AAPS has successfully filed *amicus* briefs in other appellate cases also. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914 (2000) (U.S. Supreme Court Justice Kennedy frequently citing AAPS submission); *United States v. Rutgard*, 116 F.3d 1270 (9th Cir. 1997) (reversal of a sentence as urged by an *amicus* brief submitted by AAPS).

The Semmelweis Society International, Inc. (“SSI”) is a public interest group composed of physicians, attorneys and interested citizens advocating for medical peer review with “clean hands”. With a membership approaching 200, it conducts an annual educational meeting through its medical education foundation and attempts to influence legislation aimed at improving patient care and safety through mandating good faith peer review. It has previously joined with the AAPS in filing a joint amicus brief on behalf of the Appellant in the matter of *Mileikowsky v. Tenet Health System, Inc.* on petition for Writ of Certiorari to the United States Supreme Court. SSI has also taken affirmative steps towards providing a support network for physicians who are wrongly affected by bad-faith peer review and their

families, particularly those whose legitimate attempts to positively improve patient care has unreasonably been labeled “disruptive behavior,” often thereafter leading to the revocation of their clinical privileges.

Hospital administrators frequently are more concerned about expanding their power and managing the hospital’s business operations than improving patient care, and physicians who speak out for quality therein have become a target for bad faith peer review. Unfortunately the proposed changes in JCAHO policy as to “Disruptive Behavior” will further marginalize those ethical, caring physicians who choose to speak up as they will be even more easily eliminated if these policy changes are implemented.

Of particular concern to AAPS and SSI is the growing misuse of bad-faith disciplinary procedures by hospitals commonly known as “sham peer review.” This includes retaliation against physicians who are outspoken in favor of improved patient care and safety in addition to those unfairly targeted for reasons not truly related to quality of care. Sham peer review is not only very real, but is epidemic in this country and has a dreadful chilling effect on the entire medical profession, particularly those advocates of reasonably-priced, patient-friendly quality care. Presented with numerous examples, AAPS formed a Sham Peer Review Committee to review cases and SSI’s entire membership continues to focus upon exposing the bad faith peer review problem, educating the public, advocating for reform and protecting patient safety in the process.

General Comments on the Proposed JCAHO LD.3.15 Standard

The essence of the “Proposed Standard for Disruptive Behavior Hospital” by JCAHO is to increase “top down control” in hospitals over physicians. New JCAHO initiatives, including the new MS 1.20 standard which diminishes medical staff self-governance, are being utilized to help accomplish these goals. Unfortunately, as the medical staff loses autonomy, patient care matters are unscrupulously diverted from its proper attention to that of administration, as it relentlessly moves towards total control of all hospital operational matters. This cannot be tolerated as to many patient care issues, more properly within the domain of trained physicians.

The hospital bar has been actively involved in promoting their definition of “Disruptive Behavior” in hospitals. The definition promoted by the hospital bar is purposely broadly drawn, general, vague, subjective, and essentially

undefined so as to allow hospital administrators to interpret it however they wish. This has led to widespread abuse of the “Disruptive Physician” label in hospitals. The careers of many good, highly-trained, ethical physicians have been ruined and patients have been deprived of quality care as a result.

The new JCAHO “Disruptive Physician” standard seeks to codify the hospital bar’s view of “Disruptive Behavior” into a new nationwide standard which all hospitals will adopt. If the new JCAHO standard is adopted, it will invite increased abuse of the “Disruptive Physician” label in hospitals, as hospitals will claim that they are simply following JCAHO standards in their attempt to address the “problem” physician. Sham peer review will then be methodically utilized to not only eliminate the physician from that particular health system, but to likely end his career. Once such an occurrence is entered in the National Practitioner Data Bank (NPDB), that practitioner will likely never engage in hospital practice again. Physicians who have had their privileges wrongfully terminated on a pre-textual basis (“Disruptive Physician”) will be at even greater disadvantage than they are today in seeking redress in the courts as JCAHO’s proposed new standard if codified will be a per se standard, self-authenticating and in its present proposed form can be easily contorted in such a way to eliminate virtually any physician, regardless of the merits of any accusations. Literally, no physician is safe.

“Disruptive Behavior” is an easily manipulated term that could include a physician who properly defends patient care, exercises his right of free speech on political matters, scolds an incompetent administrator, seeks to improve various clinical practices, or who properly demands adherence to excellence. Yet increasingly JCAHO attempts to allow hospital administration to brand anyone as a “disruptive physician” and then discipline him for it.

Specific Comments on the Proposed JCAHO LD.3.15 Standard:

Element 1). The leaders [presumably hospital administration] develop a code of conduct that applies to everyone who works in the organization.

This proposal violates most Medical Staff Bylaws, and applicable state laws, by encouraging hospitals to unilaterally modify or replace Medical Staff Bylaws with a new code of conduct. The Medical Staff should be self-governing and free from administrative interference. This allows the

Medical Staff to focus on patient care in an unbiased climate. Unfortunately hospital administration, through the use of lucrative employment and administrative contracts and in some cases compensating the Medical Staff Officers has thwarted the objectivity of many physicians. The phenomenon wherein many physicians are “joined at the hip” financially to the hospital has facilitated the development of sham peer review. It is those very physicians who are typically chosen to adjudicate the fate of a politically-non-aligned colleague. Their objectivity has usually already been “bought and paid for”.

Here is an actual example of a “Code of Conduct” that attempts to replace Medical Staff Bylaws. This was recently received by AAPS from one of its members:

You will at all times comply with all provisions of the Medical Staff Bylaws and the Code of Conduct Policy.

You agree that if, in the hospital’s judgment, you violate any provision of the Medical Staff Bylaws or Code of Conduct Policy, you are deemed to have voluntarily resigned your Medical Staff Membership and Privileges without any right to a fair hearing or other due process of any kind.

This Code of Conduct attempts to replace the Medical Staff Bylaws with the sole discretion of hospital administrators, in violation of the bylaws and applicable state law. This would never have occurred in the days of truly independent medical staffs but is the norm today.

A common provision of a hospital Code of Conduct policy mandates that physicians shall not complain about any quality of care or patient safety concerns to outside agencies. The Code of Conduct, as unilaterally promulgated by some hospital administrations, actively discourages compliance with **element “6.” of LD.3.10** which states: “Issues of safety and quality are openly discussed.” Strengthening the hospital’s position of control by creating a unilaterally promulgated Code of Conduct standard will have the effect of harming quality of care and patient safety in hospitals, particularly since physicians are frequently in the best position to not only detect, but also to remedy said issues pertaining to safety and quality. Hospitals, however, are more interested in control and financial benefit than true open dialogue as to improving quality of care.

As evidenced by the example provided above, there are hospital administrators today who will claim that they have already developed a very effective process for managing disruptive behavior in compliance with **element #4 of LD.3.15**: “The leaders develop processes for managing disruptive behavior.”

And, although **element #7 of LD.3.15** states: “Leaders establish a fair hearing process for those who exhibit disruptive behavior,” the actual example provided above indicates what type of procedures some hospital administrators currently believe is “fair” to physicians in hospitals. Moreover, due to widespread corruption, abuse and pervasive use of sham peer review in hospitals today, relying on “fair hearing” procedures to adjudicate highly subjective accusations will invite even more abuse than we suffer today. The Health Care Quality Improvement Act of 1986 (HCQIA) codified at 42 U.S.C. § 11101 et seq. provides qualified immunity predicated on broadly drawn safe harbor provisions to credentialing entities. Hospitals have learned that if they simply appear to follow a “procedural cookbook,” they can eliminate virtually any physician in the absence of any meaningful substantive due process.

Finally, although Element #1 provides that a code of conduct will apply to everyone who works in the organization (including management, administrative staff and governing body members), the terms “Disruptive Hospital CEO” or “Disruptive Hospital Administrator” are curiously absent from current literature pertaining to disruptive behavior in hospitals. The new JCAHO standards also fail to provide any standards or processes for dealing with disruptive behavior involving hospital administration, management or members of the governing body. A false accusation made by a hospital administrator against a physician whistleblower is a highly disruptive behavior, yet the new JCAHO standards allow such false accusations in that context with impunity.

The standards must be more narrowly drawn and JCAHO must mandate a true fair hearing procedure in the context of all peer review embodying principles of Constitutional due process and fundamental fairness. Moreover, while qualified immunity might be desirable for the individually involved physicians and certainly those objectively engaged in good faith peer review, it should never be extended to hospitals.

Element 2.) The code of conduct defines desirable and disruptive behavior.

This new JCAHO-approved code of conduct encourages false or disingenuous accusations that are difficult to disprove. This will include behavior which is “non verbal,” behavior which has an effect or potential effect on “staff morale,” behavior as exhibited in “facial expressions” and behavior that is deemed “threatening” by others. Such a broadly drawn standard is so vague as to invite abuse by hospital administration and their bought-and-paid-for medical staff allies, again denying the potentially accused physician any meaningful guidelines upon which to govern his conduct. The target will always be moving and the physician can never reasonably hit it when it is open to multiple interpretations,

This new JCAHO LD.3.15 standard will establish a precedent such that mere allegations will be sufficient to find an accused physician “guilty” of disruptive behavior and terminate his hospital privileges. An accuser’s subjective interpretation of a physician’s body language or facial expression will be all that is needed to end a physician’s career if this new JCAHO standard is adopted. This is an extremely dangerous standard which will strongly discourage physician whistleblowers from advocating for quality care and patient safety in hospitals, lest retaliation based on imaginary “non verbal” behavior be used against them. Such a phenomenon will actually work against JCAHO’s own proposed rationale for LD.3.10.

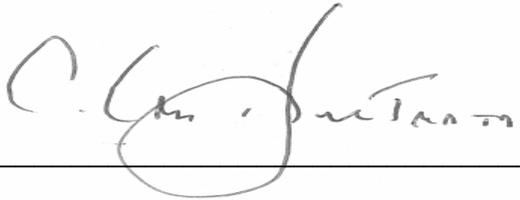
Element 7.) Leaders establish a fair hearing process for those who exhibit disruptive behavior.

Medical Staff Bylaws exclusively define the fair hearing process for physicians on staff, and this proposed Element (7) violates applicable state law by encouraging hospital administrators to bypass existing Medical Staff Bylaws.

In addition, Element (7) should include a procedure for redress in the case of false or disingenuous allegations of misconduct against physicians. With increasing frequency hospital administrators or competitors assert false allegations against physicians and there should be “a fair hearing process” to address that wrongdoing. There should be a clear statement in these proposed standards that the assertion of a false allegation for political or personal gain, or to conceal wrongdoing, is totally unacceptable and should

result in the discipline of anyone who engages in such conduct. The inclusion of such language and penalty provisions may serve as a deterrent to abuse of the process by hospitals and their aligned physicians.

Respectfully submitted this 20th day of January, 2007.



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On its Behalf and that of the AAPS