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MISSION: TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

Disruptive Behavior and Behavior That Undermines a Culture of Safety

TMA Office of the General Counsel

SEPTEMBER 2017

The Joint Commission (TJC), the Texas Medical Board, and other entities have standards that require physicians to maintain professional conduct and acceptable behavior and may discipline or take other adverse action against physicians who exhibit unprofessional conduct or disruptive or inappropriate behavior. The purpose of this document is to discuss specifically the "disruptive behavior" standard — and how that standard has evolved — and to provide examples of behavior that may and may not be classified as undermining a culture of safety.

The Rationale Behind Behavioral Standards in Health Care

Concerns for patient safety and care are at the heart of regulating physician and health care professional behavior. TJC, for instance, notes several studies that demonstrate how certain inappropriate behaviors can affect health outcome negatively, and concludes:

> Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments.[1]

The Federation of State Medical Boards also recognizes the implications of disruptive behavior: "Disruptive behavior impairs the ability of the healthcare team to function effectively thereby placing patients at risk."[2]

The Evolution of Physician Behavioral Standards

Before standards for physician behavior were nationally defined or required, requirements relating to "disruptive behavior" began to appear in hospital and medical staff bylaws. Some posit that hospitals and other facilities began to regulate health care professional behavior when, because of evolving legal liability, facilities saw trends towards vicarious liability for the actions of the health care professionals practicing in them.[3] Thus, to minimize a facility's liability for health professional action, disruptive and uncooperative behavior began to be used as the basis for revoking or withholding staff privileges.[4] Bylaws authorized hospital or medical staff leadership to request corrective action if, for example, a person's conduct was "disruptive to the operatives of the hospital,"[5] and hospitals labeled behavior as disruptive and would terminate physician privileges if it was "in the best interest of a patient or the hospital."[6]

Finding that behavioral standards for health professionals could have an effect on patient safety, courts began to affirm a hospital's right to terminate staff privileges because of disruptive or inappropriate behavior. One such court summarized the holdings of several cases that dated back to the 1920s:

1 The Joint Commission, Sentinel Event Alert Issue 40: Behaviors that undermine a culture of safety (2008), available at www.jointcommission.org/assets/1/18/SEA_40.PDF.

2 Federation of State Medical Boards, Policy on Physician Impairment (2011), available at www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol_policy-on-physician-impairment.pdf.

3 Eric W. Springer and Henry M. Casale, Hospitals and the Disruptive Heath Care Practitioner—Is the Inability to Work with Others Enough to Warrant Exclusion? 24 *Duq. L. Rev.* 379, 382 (1985).

4 See, e.g., *Weiss v. York Hosp.*, 628 F. Supp. 1392, 1399 (M.D. Pa. 1986) (in which a hospital alleged that certain physicians were excluded from being privileged on the basis of disruptive and uncooperative behavior).

5 *Friedman v. Delaware County Mem'l Hosp.*, 672 F. Supp. 171, 178 (E.D. Pa. 1987), aff'd, 849 F.2d 600 (3d Cir. 1988) and aff'd sub nom. *Appeal of Friedman*, 849 F.2d 600 (3d Cir. 1988) and aff'd sub nom. Steven A. Friedman v. Delaware County Mem'l Hosp., 849 F.2d 603 (3d Cir. 1988).

6 *Ross v. William Beaumont Hosp.*, 678 F. Supp. 655, 660 (E.D. Mich. 1988).

> [V]irtually all of the courts addressing the issue have held, and this Court hereby holds, that 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 a ground 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. … Several of these courts have emphasized that one of the principal reasons for upholding a 'disruptive conduct' bylaw of a hospital's medical staff is that quality patient care in a hospital setting requires 'team work' and compatibility between physicians, nurses and other health care personnel.[7]

As the term "disruptive physician" grew in prevalence, an effort developed on a national stage to define and develop guidelines relating to disruptive behavior. In 1999, the American Medical Association adopted a resolution directing AMA to "identify and study behavior by physicians that is disruptive to high quality patient care," and directed AMA to define the term "disruptive physician."

The following year, AMA's Council on Ethical and Judicial Affairs (CEJA) issued Report 2A00, Physicians with Disruptive Behavior, which, after being adopted at AMA's annual meeting, formed the basis for Opinion E-9.045.[8]

More significantly, in 2008, TJC published a new leadership standard that required accredited health care organizations to create a code of conduct that defines acceptable, disruptive, and inappropriate behaviors and to establish formal processes for managing unacceptable behavior.

In response to the 2008 TJC standard, AMA adopted Resolution 1 (I-08), which reflected a concern that hospitals could misuse the term "disruptive physician" if there was no clear definition of what acts by a physician rise to the level of truly disruptive behavior. In response, CEJA reviewed its Opinion E-9.045; AMA's Organized Medical Staff Section adopted model medical staff codes of conduct that followed TJC's standards;[9] and AMA adopted Policy H225.956, Behaviors that Undermine Safety, which encouraged TJC to stay implementation of its new leadership standard for a year to allow adequate time for medical staffs to bring bylaws into compliance. Despite AMA's opposition, TJC implemented its new leadership standard beginning in 2009.[10]

Continued opposition to the "disruptive behavior" standard eventually encouraged TJC to amend the standard in 2012. The standard removed references to "disruptive behavior," and instead used "behaviors that undermine a culture of safety."[11]

In making the change, TJC stated that it had used the term "disruptive behavior" because it was commonly used in the literature and recognized by most individuals in the workplace. TJC further stated it had since learned the term "is not viewed favorably by some health care practitioners and is even considered ambiguous for some audiences." TJC acknowledged that ambiguity by citing an example in which "strong advocacy for improvements in patient care can be characterized as disruptive behavior."

As of 2016, TJC continues to discourage the use of the term "disruptive behavior," and encourages the use of "unprofessional behavior" instead.[12] Even after TJC amended its behavioral standards to eliminate "disruptive behavior," the use of that term persists. Though no Texas law or regulation uses the term "disruptive behavior," the terms is used in other states, and hospital and medical staff bylaws in Texas continue to use the term.

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7 *Mahmoodian v. United Hosp.* Ctr., Inc., 185 W. Va. 59, 69, 404 S.E.2d 750, 760 (1991).

8 The Code of Medical Ethics was updated in 2016. What was formerly Policy E-9.045 is now 9.4.4, available at www.ama-assn.org/delivering-care/ama-code-medical-ethics.

9 American Medical Association, Model Medical Staff Code of Conduct (2008), available at www.ismanet.org/pdf/news/medicalstaffcodeofconduct.pdf.

10 TMA published an article in *Texas Medicine* magazine that described the new Joint Commission standard for physician behavior. See: Don't be a Jerk, *Texas Medicine* (Dec. 2009), available at www.texmed.org/template.aspx?id=8189.

11 Leadership Standard Clarified to Address Behaviors That Undermine a Safety Culture, 32 Joint Commission Perspectives 1, at 7 (Jan. 2012), available at www.jointcommission.org/assets/1/6/Leadership_standard_behaviors.pdf.

12 The Joint Commission, Sentinel Event Alert, Issue 40: Behaviors that undermine a culture of safety, available at www.jointcommission.org/sentinel_event_alert_issue_40_behaviors_that_undermine_a_culture_of_safety/ (last updated September 2016).

Evolution of the "Disruptive Behavior" Standard	
1999	AMA adopts resolution to identify and study behavior by physicians that is disruptive to patient care and define disruptive physician.
2000	CEJA issues report that forms the basis of Policy 9.4.4, defining disruptive behavior.
2008	TJC publishes Standard LD.03.01.01, requiring accredited health care organizations to create a code of conduct that defines acceptable, disruptive, and inappropriate behavior.
	TJC issues Sentinel Event Alert, explaining basis behind LD.03.01.01 and provides examples of disruptive behavior.
	AMA responds to TJC action, adopting model medical staff codes of conduct and adopting policy H-225.956, urging TJC to delay implementation of LD.03.01.01.
2009	Standard LD.03.01.01 takes effect
	CEJA reviews AMA's actions in response to TJC standard and determines that CEJA opinion and AMA model code of conduct adequately address concerns with TJC standard.
2012	TJC amends LD.03.01.01 to change term "disruptive behavior" to "behaviors that undermine a culture of safety."

What Are "Behaviors That Undermine a Culture of Safety"?

The precise types of behavior that will be labeled as disruptive, inappropriate, or undermining patient safety will depend on how they are described in applicable medical staff bylaws, employee manuals or handbooks, facility codes of conduct, employee contracts, or applicable state or federal laws and regulations. It is important to be aware of what these documents contain in relation to physician behavioral standards. While AMA ethics policy encourages members of medical staffs to "clearly describe the behaviors or types of behavior that will prompt intervention," it may not always be the case.[13]

Generally, behavior that may prompt intervention or discipline is "speak[ing] or act[ing] in ways that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or that of others to work with the physician."[14]

The AMA Model Medical Staff Code of Conduct defines "disruptive behavior" as "any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised."

More specifically, disruptive or inappropriate behavior can include "overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities."[15]

In an article on the use and misuse of the "disruptive physician" label, the Federation of State Medical Boards lists even more specific examples of both overt and passive behavior that properly could be labeled as disruptive or inappropriate.

13 §9.4.4, Physicians with Disruptive Behavior, Am. Med. Ass'n, Council on Ethical and Judicial Affairs, Code of Medical Ethics (2017).
14 Id.
15 Sentinel Event 40, supra n. 1.

Disruptive Behaviors*	
Aggressive or overt behaviors	Passive-aggressive behaviors
• Yelling	• Hostile avoidance or cold-shoulder treatment
• Foul and abusive language	• Intentional miscommunication
• Threatening gestures	• Sarcasm
• Public criticism of coworkers	• Speaking in low or muffled voice
• Insults and shaming others	• Condescending language or tone
• Intimidation	• Impatience with questions
• Invading one's space	• Malicious gossip
• Slamming objects	• Racial, gender, sexual, or religious slurs
• Physically aggressive or assaultive behavior	• Jokes about a person's personal appearance
	• Unavailability for professional matters, e.g., not answering pages
	• Implied threats, especially retribution for making complaints

* Norman Reynolds, Disruptive Physician Behavior: Use and Misuse of the Label, 98 *J. Med.* Reg. 8 (2012), available at www.fsmb.org/Media/Default/PDF/Publications/pub-jmr-misuselabel.pdf.

Advocacy for Patient Care and Safety Is Encouraged

Physicians still can, and should, be strong advocates for patient care without being disruptive. AMA describes this "appropriate behavior" in its Model Medical Staff Code of Conduct as "reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice, including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these bylaws."[16]

As recently as March 2017, TJC continues to emphasize the need to allow advocacy for improvements in patient care without the fear or risk of retaliation. In a Sentinel Event Alert that emphasizes the need for developing a safety of culture, TJC encourages "transparency in response to reports of adverse events, close calls, and unsafe conditions" while discouraging intimidating and unsettling behaviors, which can have "a detrimental impact on patient safety."[17] In fact, TJC encourages recognizing "care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements."

Being aware of the standards for both appropriate behavior and behavior that undermines a culture of safety is important. A physician's advocacy for patient care nevertheless could be considered inappropriate if the advocacy is done in ways that could be considered threatening or intimidating.

16 Model Medical Staff Code of Conduct, supra n. 9.

17 The Joint Commission, Sentinel Event Alert Issue 57: The essential role of leadership in developing a safety culture (2017), available at www.jointcommission.org/assets/1/18/SEA_57_Safety_Culture_Leadership_0317.pdf.