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Hospitals and the Disruptive Health Care Practitioner—Is the Inability to Work with Others Enough to Warrant Exclusion?

*Eric W. Springer**
*Henry M. Casale***

It isn't the experience of today that drives men mad. It is the remorse for something that happened yesterday, and the dread of what tomorrow may disclose.¹

I. INTRODUCTION

Health care professionals, particularly physicians, are prime examples of those who regret yesterday's passing and dread the advent of tomorrow. The attitude is quite understandable. Medical practice was so much easier and more comfortable twenty-five, fifteen, even ten years ago. Managing a hospital or other health care facility was child's play compared to the present. Hospital governing board members were proud of their institutions but knew very little about what went on within their walls. The hospital was the doctor's workshop; things were under control.

The pressures and dilemmas that modern hospital management² faces were not imagined just a few short years ago. Much of this pressure and many of these dilemmas come about because of the increasing involvement—some would call it intrusion—of the law in health care matters. Federal and state regulatory schemes domi-

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The authors wish to express their appreciation to Mr. Paul Verardi for his assistance in the preparation of this article.

1. R. BURDETTE, *THE GOLDEN DAY*.

2. In this article, we will use the term "hospital management" to denote not only the chief executive officer and the administrative staff, but also the medical staff leadership consisting of officers, department or service chiefs, and chairmen of committees. The term, of course, also includes hospital boards of trustees/directors.

nate the institution's and the practitioner's decisions.³ Adaptation

3. A hospital's actions, policies, and procedures must comply with the specific requirements of a plethora of federal and state statutes and regulations (for illustrative purposes, Pennsylvania law is cited).

Federal:

Child Abuse Amendments of 1984, Pub. L. 98-457, 98 Stat. 1749 (1984), Regulations, 50 Fed. Reg. 14,878 (1985), Model Guidelines for Health Care Providers to Establish Infant Care Review Committees, 50 Fed. Reg. 14,493 (1985); Social Security Act (Medicare Provisions), 42 U.S.C.A. §§ 1395c-1395xx (West 1983), Medicare Conditions of Participation for Hospitals, 42 C.F.R. § 405.1011 (1984), Medicare Regulations for the Detection and Prevention of Fraud and Abuse, 42 C.F.R. § 420.1 (1984); Social Security Amendments of 1983 (establishing a Prospective Payment Mechanism for Inpatient Medicare Costs), Pub. L. 98-21, § 601, 97 Stat. 149 (codified at 42 U.S.C.A. § 1395ww (West 1983)), Regulations, 42 C.F.R. § 405.470 (1984); National Health Planning and Resources Development Act of 1974, 42 U.S.C.A. § 300k (West 1983), Regulations, 42 C.F.R. §§ 121-124 (1985); Equal Employment Opportunities Act, 42 U.S.C.A. § 2000-c (West 1983), Regulations, 29 C.F.R. §§ 1602.7-1602.14 (1985); Rehabilitation Act of 1973, 29 U.S.C.A. § 701 (West Supp. 1985); Fair Labor Standards Act (including Equal Pay Act) 29 U.S.C.A. § 201 (1982), Regulations, 29 C.F.R. §§ 516.2-516.10 (1985); Age Discrimination in Employment Act, 29 U.S.C.A. §§ 621-634 (West Supp. 1985), Regulations, 29 C.F.R. § 860 (1985); Hill-Burton Act, 42 U.S.C.A. § 291 (1982), Regulations, Services for Persons Unable to Pay, 42 C.F.R. § 124.501 (1985); Drug Abuse Prevention, Treatment and Rehabilitation Act, Admission of Drug Abusers to Private and Public Hospitals, 42 U.S.C.A. § 290ee-2 (West Supp. 1985), Regulations, 45 C.F.R. §§ 84.1-84.47 (1985); Drug Abuse Prevention, Treatment and Rehabilitation Act, Confidentiality of Patient Records, 42 U.S.C.A. § 290ee-3 (West Supp. 1985), Regulations, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. § 2 (1985); Food, Drug and Cosmetics Act, 21 U.S.C.A. §§ 301-392 (1982), Regulations, Institutional Review Boards, 21 C.F.R. §§ 56.101-56.124, 21 C.F.R. §§ 813.60-813.79 (1985), and Informed Consent of Human Subjects, 21 C.F.R. §§ 50.20-50.27 (1985); Federal Controlled Substances Act, 21 U.S.C.A. § 811 (1982), Regulations, 21 C.F.R. § 1306 (1985).

State: (Pennsylvania)

Public Welfare Code, PA. STAT. ANN. §§ 901-1059 (Purdon 1968), Rules and Regulations, General and Special Hospitals, 28 PA. ADMIN. CODE §§ 101.1-155.8 (1983); Non-Profit Corporations Law, 15 PA. CONS. STAT. ANN. § 7101 (Purdon 1984); Health Care Facilities Act, 35 PA. CONS. STAT. ANN. §§ 448.101-448.903 (Purdon Supp. 1985), Regulations, 28 PA. ADMIN. CODE §§ 405.1-405.5 (1985); Medical Assistance for the Aged, 62 PA. CONS. STAT. ANN. § 444.1 (Purdon Supp. 1985); Fraud and Abuse Control, 62 PA. CONS. STAT. ANN. §§ 1401-1411 (Purdon Supp. 1985); Child Protective Services Law, 11 PA. CONS. STAT. ANN. § 2201 (Purdon Supp. 1985); Peer Review Protection Act, 63 PA. CONS. STAT. ANN. §§ 425.1-425.4 (Purdon Supp. 1985); Professional Health Services Malpractice Act, 40 PA. CONS. STAT. ANN. § 1301.103 (Purdon 1985); Drug and Alcohol Abuse Control Act, 71 PA. CONS. STAT. ANN. §§ 1690.101-1690.109 (Purdon Supp. 1985); Anatomical Gifts, 20 PA. CONS. STAT. ANN. § 8601 (Purdon Supp. 1985); Reports by Emergency Room Personnel, 75 PA. CONS. STAT. ANN. § 3755 (Purdon 1985); Liquor Control Code, 47 PA. CONS. STAT. ANN. § 4-408.4 (Purdon Supp. 1985); An Act Prohibiting Smoking in Patients' Rooms in Hospitals, 35 PA. CONS. STAT. ANN. § 361 (Purdon Supp. 1985); Tests for Newborn Infants, 35 PA. CONS. STAT. ANN. § 621 (Purdon 1977); Reporting of Injuries by Firearms or Criminal Act, 18 PA. CONS. STAT. ANN. § 5106 (Purdon 1983); Reporting Incidents of Professional Misconduct Act, Act No. 1985-48, 1985 PA. LEGIS. SERV. 269 (to be codified at 35 PA. CONS. STAT. ANN. § 448.806.1).

In order to be accredited, the hospital must also comply with the Joint Commission on Accreditation of Hospitals, ACCREDITATION MANUAL FOR HOSPITALS 1986 (hereinafter cited as JCAH), and in the case of Osteopathic Hospitals, the American Osteopathic Association, ACCREDITATION REQUIREMENTS OF THE AMERICAN OSTEOPATHIC ASSOCIATION 1984 (hereinafter

of technological innovation must pass the scrutiny of an intimidating and time-consuming array of approval mechanisms.⁴ So-called medico-moral questions arise with a frequency that makes them commonplace, but nevertheless deeply troubling.⁵

It is no wonder many practitioners react to the law and lawyers angrily. Obviously they are puzzled, frustrated and frightened. Everything has changed; they seem to have lost control of what used to be their sacred and familiar territory. In a very short span of years, the legal system has moved from a posture of benign indifference about health matters, to an attitude of active intervention in all aspects of health care delivery.⁶ Legal developments

cited as A.O.A.).

4. National Health Planning and Resource Development Act of 1974, 42 U.S.C.A. § 300k (West 1983), Regulations, 42 C.F.R. §§ 121-124 (1985); Health Care Facilities Act, 35 PA. CONS. STAT. ANN. §§ 448.101-448.903 (Purdon Supp. 1985), Regulations, 28 PA. ADMIN. CODE §§ 405.1-405.5 (1985); THE PROPOSED PENNSYLVANIA STATE HEALTH PLAN 1981-1986 (2nd Ed. 1981). A poignant example of the significance of "approval mechanisms" is found in *Statewide Health Coordinating Council v. General Hosps. of Humana, Inc.*, 280 Ark. 443, 660 S.W.2d 906 (1983), *cert. denied*, 104 S. Ct. 2386 (1984). In this case, Humana applied for, and was granted, a Certificate of Need (CON) which was necessary to build a 150-bed community hospital in 1982. Humana began construction of the hospital while three parties who had originally opposed the CON asked for, and received, a review by an independent state agency. The agency affirmed the award of the CON and its decision was affirmed by the circuit court. The Supreme Court of Arkansas, however, found that the grant of the CON was inconsistent with the state health plan. It thus reversed the award of the CON and forced Humana to halt construction of the now partially-finished hospital.

5. Health care practitioners and hospital executives must deal with critical life or death decisions more often than any other segment of the professional world. Medical technological advances have not only expanded the professional ability to alleviate illness and disease, but at the same time, those advances have also extended the existence of those with debilitating or terminal illness. In addition to troubling questions regarding the application of life-perpetuating technology to terminally ill or permanently comatose patients, there are equally compelling decisions which must be made concerning withholding treatment or nourishment from some patients or withdrawing treatment after it has been initiated. Of course, the matter of choosing the one person who shall receive beneficial, but costly or limited, therapeutic services is equally troubling. *See, e.g., Angell, Cost Containment and the Physician*, 254 J. A.M.A. 1203 (Sept. 6, 1985); F. CHILDRESS, WHO SHOULD DECIDE? PATERNALISM AND HEALTH CARE (1982); Citron, *Sounding Board, Trustees at the Focal Point*, 313 NEW ENG. J. OF MED. 1223 (Nov. 7, 1985); Special Report, *Technology, Financing and Rationing: Where to From Here in the DRG Era*, 17 FED'N OF AMER. HOSPS. REV. 12 (May/June 1984); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

6. Indeed, the legal climate toward hospitals has shifted from total immunity to one of almost strict liability for all tortious acts committed under its roof. *See generally* Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975). Language from the case of *Atassi v. Massillon Community Hosp.*, CA-6075 (Ct. App. Stark Cty., July 25, 1983), illustrates the commonplace judicial recognition of hospital liability:

At this point we observe in passing, what must be obvious to all, that the legal profes-

have required hospital management to institute such things as peer review and credentialing programs which increasingly control the professional's practice patterns. This comes about as a consequence of the reality that today the hospital stands at risk for everything that happens within the institution, including legal responsibility for the acts of the medical practitioners on the so-called medical staff. In the past, hospitals were not liable for the acts of staff members because they were considered to be independent practitioners. Now, under expanding theories of corporate liability,⁷ hospitals are sued for physician-caused adverse patient care

sion generally, and the judiciary specifically, recognize that if hospitals are to be derivatively liable for the negligence of the physicians they allow to practice therein, they must be given a free hand to choose those whose potential misconduct might bankrupt them and put them out of business.

Atassi, slip op. at 3.

Cases which have held the hospital liable for the negligence of its staff appointees though they were intended to be independent contractors include: *Walker v. Winchester Memorial Hosp.*, 585 F. Supp. 1328 (W.D. Va. 1984); *Stewart v. Midani*, 525 F. Supp. 843 (N.D. Ga. 1981); *Gregg v. National Medical Health Care Servs.*, 145 Ariz. 51, 699 P.2d 925 (1985); *Schagrin v. Wilmington Medical Center*, 304 A.2d 61 (Del. Super. Ct. 1973); *Garcia v. Tarrío*, 380 So. 2d 1068 (Fla. Dist. Ct. App. 1980); *Holton v. Resurrection Hosp.*, 88 Ill. App. 3d 655, 410 N.E.2d 969 (1980); *Paintsville Hosp. Co. v. Rose*, 683 S.W.2d 255 (Ky. 1985); *Williams v. St. Claire Medical Center*, 657 S.W.2d 590 (Ky. Ct. App. 1983); *Mehlman v. Powell*, 281 Md. 247, 378 A.2d 1121 (1977); *Grewe v. Mt. Clements General Hosp.*, 404 Mich. 240, 273 N.W.2d 429 (1978); *Hardy v. Brantley*, 471 So. 2d 358 (Miss. 1985); *Arthur v. St. Peters Hosp.*, 169 N.J. Super. 575, 405 A.2d 443 (1979); *Reynolds v. Swigert*, 102 N.M. 504, 697 P.2d 504 (1984); *Hippocrates Mertsaris v. 73rd Corp.*, 105 A.D.2d 67, 482 N.Y.S.2d 792 (1984); *Willoughby v. Wilkins*, 65 N.C. App. 626, 310 S.E.2d 90 (1983); *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980); *Smith v. St. Francis Hosp.*, 676 P.2d 279 (Okla. Ct. App. 1983); *Themins v. Emanuel Lutheran Charity Board*, 54 Or. App. 901, 637 P.2d 155 (1981); *Caplan v. Divine Providence Hosp.*, 287 Pa. Super. 364, 430 A.2d 647 (1980); *Simmons v. St. Clair Memorial Hosp.*, 332 Pa. Super. 444, 481 A.2d 870 (1984); *Edmonds v. Chamberlain Memorial Hosp.*, 629 S.W.2d 28 (Tenn. Ct. App. 1981); *Adamski v. Tacoma General Hosp.*, 20 Wash. App. 98, 579 P.2d 970 (1978).

7. The doctrine of hospital corporate negligence was first enunciated in the case of *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965). The doctrine basically holds a hospital liable—as a corporate entity—for the actions of the medical staff when the hospital could, in some way, have prevented injury to a patient caused by a medical staff appointee. Subsequently, this doctrine has been utilized by the courts to require hospitals to exercise reasonable care to insure that the physicians appointed to the hospital's medical staff are competent. (We refer to this process as *credentialing*). See, e.g., *Early v. Bristol Memorial Hosp.*, 508 F. Supp. 35 (E.D. Tenn. 1980); *Storrs v. Lutheran Hosps. and Homes Soc'y of America, Inc.*, 661 P.2d 632 (Alaska 1983); *Tucson Medical Center, Inc. v. Misevch*, 113 Ariz. 34, 545 P.2d 958 (1976); *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); *Kitto v. Gilbert*, 570 P.2d 544 (Colo. Ct. App. 1977); *Buckley v. Lovallo*, 2 Con. Supp. 579, 481 A.2d 1286 (1984); *Mitchell County Hosp. Auth. v. Joiner*, 229 Ga. 140, 189 S.E.2d 412 (1972); *Ferguson v. Gonyaw*, 64 Mich. App. 685, 236 N.W.2d 543 (1975); *Gridley v. Johnson*, 476 S.W.2d 475 (Mo. 1972); *Moore v. Board of Trustees of Carson-Tahoe Hosp.*, 88 Nev. 207, 495 P.2d 605 (1972); *Corletto v. Shore Memo-*

events and they are found liable. In one sense, this change in the perceived structure of the health delivery system has caused some individuals to act unprofessionally and to become disruptive, and an emerging and distinct aspect of hospital responsibility is handling the disruptive health care practitioner.⁸

The problem of handling the disruptive health care practitioner is at once complex and pervasive. It is more widespread than most imagine. It involves social, collegial, clinical and legal aspects in a complicated human calculus that defies simple solution. The problem exists in large and small hospitals, in rural and urban settings, in teaching institutions and community health centers.

In an earlier time, hospitals and medical organizations accepted, or at least tolerated, disruptive behavior for a variety of reasons.⁹ Today, accepting or tolerating such behavior is increasingly diffi-

rial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975); *Felice v. St. Agnes Hosp.*, 65 A.D.2d 388, 411 N.Y.S.2d 901 (1978); *Bost v. Riley*, 44 N.C. App. 638, 262 S.E.2d 391, *petition denied*, 300 N.C. 194, 269 S.E.2d 621 (1980); *Hannola v. City of Lakewood*, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398 (1975); *Pedroza v. Bryant*, 101 Wash. 2d 226, 677 P.2d 166 (1984); *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

8. The emphasis of this article is on physicians and dentists. However, the term health care professional is more accurate because nurse practitioners, psychologists, podiatrists and similar health care professionals other than physicians are subject to the same stresses and pressures of the hospital environment and act disruptively. Moreover, medical staff appointment and clinical privileges are being opened to a variety of health care professionals. See, e.g., JCAH, *supra* note 3, at 10.1.1.1; CAL. HEALTH AND SAFETY CODE § 1316 (West 1977) and § 1316.5 (West 1980); See also D.C. CODE ANN § 32-1307(c) (1985) which provides as follows:

No provision of District of Columbia law, institutional or staff bylaw of a facility or agency, rule, regulation, or practice shall prohibit qualified certified registered nurse anesthetists, certified nurse-midwives, certified nurse practitioners, podiatrists, or psychologists from being accorded clinical privileges and appointed to all categories of staff membership at those facilities and agencies that offer the kinds of services that can be performed by either members of these health professions or physicians. As used in this subsection, the word 'certified' denotes certification by the following organizations: For nurse practitioners, the American Nurses' Association, the National Association of Pediatric Nurse Associates and Practitioners, or the NAACOG Certification Corporation [Nurses Association of the American College of Obstetricians and Gynecologists]; and for nurse-midwives, the American College of Nurse-Midwives. Use of the words 'certified registered' for nurse anesthetists denotes certification by the Council on Certification of the American Association of Nurse Anesthetists or recertification by the Council of Recertification of the American Association of Nurse Anesthetists. The Mayor may add to this list acceptable certifying organizations through rules adopted under § 32-1304. These certification requirements shall control in the absence of specialty licensing for these health professionals.

9. Physicians were initially loath to become involved in what were considered to be the private problems of their colleagues. Reasons for this reluctance ranged from "there but for the grace of God go I," to fears of litigation. See generally Hirsh, *The Medical-Legal Implications of the Errant or "Sick" Physician*, MED. TRIAL TECH. Q. 377 (1976).

cult, at least in the hospital setting, because the clear trend of the law is to hold the hospital—as a corporate entity—accountable for all activity which occurs within its walls. It is clear that a hospital is now at risk for all professional activity which takes place under its jurisdiction.¹⁰ Some courts have extended this risk to the medical staff leadership¹¹ and a few have suggested that the entire hospital medical staff may be subject to liability under certain circumstances.¹² Thus, contrary to an earlier time when it was very much accepted, there is a low level of tolerance for disruptive behavior today.

This article will explore several issues relating to the disruptive health care practitioner in the hospital context. Initially, "disruptive behavior" will be defined. After discussing the medical staff appointment process and the importance of well-drafted medical staff bylaws, we will then examine how and under what circumstances hospital management can act in handling the disruptive practitioner. The approach the hospital takes may depend on whether the practitioner is making an application for initial appointment, is being considered for reappointment, or is in the middle of his term of appointment. Underlying this discussion is the critical issue of balancing the practitioner's interests and those of the institution. This will lead us to a consideration of whether disruptive behavior alone, without evidence of a direct adverse impact on either patient care or hospital functions, is sufficient to warrant a practitioner's exclusion from the hospital. The article will conclude with a section on due process concerns and, what is extremely important, a section on the range of hospital responses short of invoking formal due process procedures.

It is our conclusion that the clear trend of the cases supports the view that a hospital may deny initial appointment, terminate an appointed practitioner or deny reappointment, solely on the basis of the practitioner's disruptive behavior. It is our view that the trend is appropriate and justified. We also are of the opinion that medical and administrative hospital leadership must be able to

10. See *supra* notes 6 & 7 and accompanying text.

11. *Johnson v. St. Bernard Hosp.*, 79 Ill. App. 3d 709, 399 N.E.2d 198 (1979); *Simmons v. St. Clair Memorial Hosp.*, 332 Pa. Super. 444, 481 A.2d 870 (1984); *Wilson v. McCarthy*, 57 A.D.2d 617, 393 N.Y.S.2d 770 (1977).

12. *Weiss v. York Hosp.*, 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 1777 (1985); *Bhatt v. Uniontown Hosp.*, C.A. No. 83-2455 (W.D. Pa. Mar. 7, 1984); *Corleto v. Shore Memorial Hosp.*, 138 N.J. Super. 302, 350 A.2d 534 (1975). See also Harty and Mulholland, *The Legal Status of the Hospital Medical Staff*, 22 St. Louis U.L.J. 485 (1978).

employ a range of administrative strategies to deal rapidly and effectively with the disruptive practitioner short of a structured due process hearing. We believe nonetheless, that fundamental due process considerations generally apply and that practitioners must be accorded a full and fair opportunity to defend themselves.

II. DISRUPTIVE BEHAVIOR DEFINED

The disruptive practitioner is by definition, contentious, threatening, unreachable, insulting and frequently litigious. He will not, or cannot, play by the rules, nor is he able to relate to or work well with others.¹³ The disruptive health care practitioner can be one who has recently entered into practice or an individual with years of experience. He, or she, can be white or black, native or foreign born, a specialist or general practitioner, educated in this country or foreign trained. This practitioner often falls within the classification of the impaired or sick physician,¹⁴ in that the underlying reason for the practitioner's abusive conduct may be a mental or emotional problem.¹⁵ However, that is not always the case. Sometimes the person is simply a disruptive or abrasive human being.

The manifestation of disruptive behavior sometimes takes bi-

13. See, e.g., *Silver v. Castle Memorial Hosp.*, 53 Hawaii 475, 497 P.2d 564 (1972), cert. denied, 409 U.S. 1048 (1972); *Bricker v. Sceva Speare Memorial Hosp.*, 111 N.H. 276, 281 A.2d 589 (1971); *Van Campen v. Olean Gen. Hosp.*, 210 App. Div. 204, 205 N.Y.S. 554 (1924), *aff'd mem.*, 239 N.Y. 615, 147 N.E. 219 (1925).

14. See generally Special Report, 82 MICHIGAN MEDICINE 278-294 (1982); A.M.A. Council on Mental Health, *The Sick Physician*, 223 J. A.M.A. 684 (Feb. 1973); Berman, *Legal Mechanisms for Dealing with the Disabled Physician in Maryland*, 25 MD. ST. MED. J. 41 (Feb. 1976); Canavan, *Advocacy*, 81 JOURNAL OF MEDICAL SOC'Y OF N.J. 140 (Feb. 1984); Gordon, *Growing Pressure to Act Against Incompetent Doctors*, PHYSICIAN'S MANAGEMENT 56 (May 1975); Hirsh, *The Medical-Legal Implications of the Errant or Sick Physician*, MED. TRIAL TECH. Q. 377 (1976); Martindale, *Subtle Enablers*, 80 JOURNAL OF THE ARK. MEDICAL SOC'Y 531 (1984); Modlin, *The Disabled Physician*, 76 J. KAN. MED. SOC'Y 295 (1975); Niven, Hurt, Morse & Swenson, *Alcoholism in Physicians*, 59 MAYO CLINIC PROCEEDINGS 12 (1984); Physician's Committee, *Special Report*, 75 N.Y.S. J. MED. 420 (1975); Rensberger, *The Doctors Who Need the Care of Other Doctors*, N.Y. Times, May 1, 1977, § 4 at 8, col. 3; Scheiber, *A Comprehensive Statewide Approach to the Sick Doctor*, 32 ARIZ. MED. 933 (1975); Shapiro, Pinsker & Shaler, *The Mentally Ill Physician as Practitioner*, 232 J. A.M.A. 725 (1975); Silver, *The Medical Insurance Disease*, 222 NATION 366 (1976); Talbott, Holderfield, Shoemaker & Atkins, *The Disabled Doctors Plan for Georgia*, 65 J. MED. ASS'N GA. 71 (Mar. 1976); Tanous, *The Oasis Syndrome: The Physicians Need for Refuge*, 28 AMERICAN FAMILY PHYSICIAN 121 (Oct.-Dec. 1983); Waring, *Psychiatric Illness in Physicians; A Review*, 15 COMPREHENSIVE PSYCHIATRY 519 (1974). Note, *New Treatment for Disabled Physicians: Proposed Amendments to the Medical Practices Act of 1977*, 42 ALB. L. REV. 32 (1978).

15. See, e.g., *Don v. Okmulgee Memorial Hosp.*, 443 F.2d 234 (10th Cir. 1971); *Even v. Longmont United Hosp. Ass'n.*, 629 P.2d 1100 (Colo. Ct. App. 1981); *Rao v. Auburn General Hosp.*, 19 Wash. App. 124, 573 P.2d 834 (1978).

zarre forms.¹⁶ The disruptive practitioner is often clinically competent. Indeed, he will believe himself to be more competent than others on the medical staff. It is not uncommon to find that a disruptive practitioner is, in fact, highly intelligent, clinically superior, even medically outstanding.¹⁷ However, the reason for his disruptiveness, his inability to get along with others, sometimes affects his clinical judgment. He is totally convinced that he is right. Those who would question him or seek to have him behave differently, whether they are colleagues or not, are seen to be motivated by ignorance, stupidity, jealousy or a desire to destroy him as an economic competitor. They are also believed to be weak and vulnerable. In fact, the objects of his unacceptable behavior are most frequently those who, by virtue of their positions, are weak and vulnerable. He may not openly take on the strong and prestigious, but rather seek to undermine and intimidate those who can neither avoid him nor fight back. For these reasons, and regardless of what may cause him to act as he does, he is a formidable person.

He is not, of course, to be confused with the physician who is merely "different." Those who express unorthodox opinions, display unusual tastes or adopt alternative life-styles may well be out of step with the majority of the medical staff, hospital management or the board. Nevertheless, as long as they discharge their responsibilities to the hospital and to their patients and are not fomenting trouble, the hospital has a positive obligation to treat them with the same degree of tolerance and acceptance it affords the "regulars."¹⁸ Only when personal idiosyncrasies, as expressed

16. In *Leonard v. Board of Directors of Prowers County Hosp. Dist.*, 673 P.2d 1019 (Colo. Ct. App. 1983), the plaintiff, in response to the hospital board's request for more open communications, sent a memorandum to the hospital attorney which included a depiction of "a set of lips on the posterior of a nude figure." *Id.* at 1021.

17. "Mere intellectual power and scientific achievement without uprightness of character may be more harmful than ignorance. Highly trained intelligence combined with disregard of the fundamental virtues is a menace." *Lawrence v. Bairy*, 239 Mass. 424, 429, 132 N.E. 174, 176 (1921). For "disruptive physician" cases in which the court specifically made note of the fact that the physician's competence was not at issue, see, e.g., *Meridith v. Allen County War Memorial Hosp. Comm'n.*, 397 F.2d 33 (6th Cir. 1968); *Robbins v. Ong*, 452 F. Supp. 110 (S.D. Ga. 1978); *McMillan v. Anchorage Community Hosp.*, 646 P.2d 857 (Alaska 1982); *Even v. Longmont United Hosp. Assn.*, 629 P.2d 1100 (Colo. Ct. App. 1981); *Spencer v. Children's Hosp.*, 419 So. 2d 1307 (La. Ct. App. 1982), *rev'd. on other grounds*, 432 So. 2d 823 (La. 1983); *Bricker v. Sceva Speare Memorial Hosp.*, 111 N.H. 276, 281 A.2d 589 (1971); *Grodjesk v. Jersey City Medical Center*, 135 N.J. Super. 393, 343 A.2d 489 (1975); *Siegel v. St. Vincent Charity Hosp. and Health Center, No. 79376* (Cuyahoga County, Ohio Oct. 31, 1985); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398 (1975).

18. See, e.g., *United States v. Halifax Hosp. Medical Center*, 1981-1 Trade Cas. (CCH) ¶ 64,151 (M.D. Fla. 1981) and *In re Forbes Health System Medical Staff*, 94 F.T.C. 1042

in words or deeds, begin to affect the ability of others to get their jobs done, or impinge on their right to go about their own business free of burdensome harassment, or when such idiosyncrasies begin to interfere with the practitioner's ability to perform well professionally, is action by the hospital indicated.

The hospital's decision whether to take action, however, is not an easy one to make and the hospital is at risk whatever action it takes. If it does nothing in the face of behavior that is disruptive, its inaction can cause serious morale problems, even to the extent of losing its employees and causing the rest of the medical staff to become disaffected. The hospital literally can, by its inaction, allow its effectiveness to be destroyed. On the other hand, if the hospital acts against a practitioner who is merely "different," it opens itself to the possibility of injunctive action and money damages.¹⁹

The courts have had to deal with a variety of types of disruptive behavior in the hospital setting. The following examples are illustrative: attacks levelled at other medical staff appointees which are personal and irrelevant, or go beyond the bounds of fair professional comment;²⁰ impertinent and inappropriate comments writ-

(1979) (both cases involved discrimination against those physicians who participated in a "Health Maintenance Organization"); *In the Matter of Sherman A. Hope*, 98 F.T.C. 58 (1981) (five established physicians required to cease their coercion activities regarding hospital policy to recruit "new" physicians to the area); *Ascherman v. San Francisco Medical Soc'y*, 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974) (conspiracy and discrimination against physician because he was an early proponent of the Medicare program). *Compare Cipriotti v. Board of Directors of Northridge Hosp. Found. Medical Center*, 147 Cal. App. 3d 144, 196 Cal. Rptr. 367 (1983) (summary suspension proper here where physician condoned the use of controlled drugs at parties at his residence and also displayed a hashish pipe and condoned the use of dangerous drugs in the presence of employees and a patient).

19. See, e.g., *McElhinney v. William Booth Memorial Hosp.*, 544 S.W.2d 216 (Ky. 1977), discussed *infra* notes 23, 90-94 and accompanying text.

20. See, e.g., *Pontius v. Children's Hosp.*, 552 F. Supp. 1352 (W.D. Pa. 1982) (doctor tried to convince the parents of a patient to change their decision of using another physician, instead of himself, to operate on their daughter, and exhibited a general inability to cooperate with other surgeons and medical staff appointees); *Hoberman v. Lock Haven Hosp.*, 377 F. Supp. 1178 (M.D. Pa. 1974) (uncontrolled emotional outbursts, coercion and harassment of other doctors who did not refer all of their cases to him); *McMillan v. Anchorage Community Hosp.*, 646 P.2d 857 (Alaska 1982) (series of problems and incidents occurring over a two year period between Dr. McMillan and other staff physicians, the nursing staff, a nurse anesthetist and the relatives of several patients); *Dunbar v. Hosp. Auth. of Gwinnett County*, 227 Ga. 534, 182 S.E.2d 89 (1971) (doctor continuously stated he was going to change everything in the hospital and made general derogatory statements with respect to other professionals); *Silver v. The Queen's Hosp.*, 63 Hawaii 430, 629 P.2d 1116 (1981) (doctor treated and billed a patient without the knowledge of the physician who admitted her for treatment; doctor further did not hesitate to violate the rules and regulations of those hospitals where he was appointed; and, in the hearings that followed the denial of his appointment at Queen's Hospital, he charged two doctors with subornation of

ten (or "cute" illustrations drawn) in patient medical records, or other official documents, impugning the quality of care in the hospital, or attacking particular practitioners, nurses or hospital policy;²¹ and sexual harassment of nurses, other hospital employees or patients.²²

Disruptive behavior may also manifest itself as non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or impute stupidity, bad motives or incompetence. The content of the criticism may ostensibly express concern for the patient, implying thereby lesser standards on the part of the person criticized or, in fact, of the hospital itself. Such criticism can be very disarming. To attempt to refute it is to appear to disagree with the standard or, worse, to acknowledge that a lesser standard is acceptable. Furthermore, the practitioner himself is able to disguise his real motive, which is to hurt, disrupt and harass, behind high-sounding words and his "right" to say whatever he wants in the interest of better patient care.²³

perjury, alleged that the hospital condoned medical malpractice, and alleged that insurance companies told the board of directors which physicians should be admitted to the staff); *Yarnell v. Sisters of St. Francis Health Service, Inc.*, ___ Ind. App. ___, 446 N.E.2d 359 (1983) (doctor was threatening and abusive to other medical staff appointees and was generally disruptive to hospital procedures); *Anderson v. Trustees of Caro Community Hosp.*, 10 Mich. App. 348, 159 N.W.2d 347 (1968) (evidence against Dr. Anderson was "replete with examples of vilification, screaming and profanity"); *Thompson v. Grays Harbor Community Hosp.*, 36 Wash. App. 300, 675 P.2d 239 (1983) (doctor referred to another physician as "a butcher").

21. See, e.g., *Cipriotti*, 196 Cal. Rptr. 367 (placed inappropriate and disrespectful comments on a patient's chart); *Leonard v. Board of Directors of Prowers County Hosp. Dist.*, 673 P.2d 1019 (Colo. Ct. App. 1983) (doctor drew a set of lips on posterior of nude figure); *Kiracofe v. Reid Memorial Hosp.*, ___ Ind. App. ___, 461 N.E.2d 1134 (1984) (entered inappropriate and defamatory statements in medical records).

22. See, e.g., *Belanoff v. Grayson*, 98 A.D.2d 353, 471 N.Y.S.2d 91 (1984); *Bolling v. Baker*, 671 S.W.2d 559 (Tex. App. 1984). See also Horthy, *Sexual Harassment, What to do About It*, ACTION-KIT FOR HOSPITAL LAW (July 1981); Horthy, *Sexual Harassment*, HOSPITAL LAW Ch. 2 § 4 (July 1985); Yollick and Hirsh, *Sexual Harassment in the Hospital Workplace: It Involves Everyone and It Ain't Legal*, MED. TRIAL TECH. Q. 442 (1984); Annot., 15 A.L.R. 3rd 1179 (1967).

23. See, e.g., *McElhinney*, 544 S.W.2d 216 (Ky. 1977). In this case, the court characterized the allegedly disruptive physician as an especially competent, dedicated and busy surgeon who had incurred the wrath of the hospital's administration when he voiced his objections to what he perceived to be hospital-condoned substandard patient care. However, in a subsequent federal antitrust suit which was based upon his staff termination, *McElhinney v. Medical Protective Co.*, 549 F. Supp. 121 (E.D. Ky. 1982), it was revealed that the real reason behind Dr. McElhinney's termination was his disruptive conduct. "[H]e was a troublemaker. It appears that each defendant had a confrontation with plaintiff in which vulgarities, religious or ethnic slurs were made by plaintiff. The evidence also shows that defendants were concerned with plaintiff simultaneously attempting to cover-up on his own errors while making their errors public." *Id.* at 135. See also *Buckner v. Lower Florida Keys*

Other examples include: refusal to accept medical staff assignments or to participate in committee or departmental affairs on anything but his own terms or to do so in a disruptive manner;²⁴ imposing idiosyncratic requirements on the nursing staff which have nothing to do with better patient care but serve only to burden the nurses with special techniques and procedures;²⁵ rude or abusive conduct to nurses or other hospital employees;²⁶ abusive

Hosp. Dist., 403 So. 2d 1025 (Fla. Dist. Ct. App.), *petition for rev. denied*, 412 So. 2d 463 (Fla. 1982). The court characterized plaintiff as one who "pontifically lauded himself, while castigating the medical community in which he practiced with vitriolic and intemperate remarks." *Id.* at 1027.

24. *Harris v. Group Health Ass'n*, 662 F.2d 869 (D.C. Cir. 1981) (pattern of reporting to work late, failure to visit satellite laboratories, refusal to work weekends); *Laje v. R. E. Thomason Gen. Hosp.*, 564 F.2d 1159 (5th Cir. 1977) (doctor's history replete with instances of insubordination); *Meredith v. Allen County War Memorial Hosp. Comm'n.*, 397 F.2d 33 (6th Cir. 1968) (physician refused to handle any emergency cases); *Cipriotti*, 196 Cal. Rptr. 367 (failure of doctor to attend staffing conferences); *Dunbar v. Hospital Auth. of Gwinnett County*, 227 Ga. 534, 182 S.E.2d 89 (1971) (violated restrictions imposed on temporary privileges); *Glass v. Doctors Hosp.*, 213 Md. 44, 131 A.2d 254 (1957) (doctor's attempt "to take control" of hospital described as follows: "[B]ehind this skeletal history looms conflicts of personality and battles for administrative control of the hospital. . . ." *Id.* at 51, 131 A.2d at 257); *Grodjesk v. Jersey City Medical Center*, 135 N.J. Super. 393, 343 A.2d 489 (1975) (disharmony, mistrust and lack of cooperation between two oral surgeons and the director of the department of dentistry); *Theissen v. Watonga Municipal Hosp. Board*, 550 P.2d 938 (Okla. 1976) (doctor did not keep his "promises" to abide by hospital rules and failed to carry out medical staff duties in a proper, professional and dependable manner); *Clair v. Centre Community Hosp.*, 317 Pa. Super. 25, 463 A.2d 1065 (1983) (physician refused to treat indigent patients); *Ritter v. Board of Comm'rs. of Adams County Public Hosp. Dist. No. 1*, 96 Wash. 2d 503, 637 P.2d 940 (1981) (repeated performance of surgery in violation of hospital rules, chart delinquencies and failure to cooperate with administration and staff); *Rao v. Auburn General Hosp.*, 19 Wash. App. 124, 573 P.2d 834 (1978) (refusal to abide by medical staff bylaws).

25. *See, e.g., Pontius v. Children's Hosp.*, 552 F. Supp. 1352 (W.D. Pa. 1982) (ordered intensive care nursing staff not to permit any hospital resident to order anything for his patient without his approval); *Ladenheim v. Union County Hosp.*, 76 Ill. App. 3d 90, 394 N.E.2d 770 (1979) (doctor left orders that no nurse was to institute cardiopulmonary resuscitation on any of his patients without his permission).

26. *See, e.g., Even v. Longmont United Hosp. Ass'n*, 629 P.2d 1100 (Colo. Ct. App. 1981) (doctor's uncontrolled temper and actions intimidated those working with him and caused strong hostilities); *Dunbar v. Hospital Auth. of Gwinnett County*, 227 Ga. 534, 182 S.E.2d 89 (1971) (attitude toward and communication with nursing staff created friction); *Kiracofe v. Reid Memorial Hosp.*, ___ Ind. App. ___, 461 N.E.2d 1134 (1984) (doctor refused to explain orders and exhibited abusive behavior toward nurses); *Spencer v. Children's Hosp.*, 419 So. 2d 1307 (La. Ct. App. 1982), *rev'd on other grounds*, 432 So. 2d 823 (La. 1983) (35% of the nursing staff had threatened to resign due to Dr. Spencer's abusive treatment); *Bricker v. Sceva Speare Memorial Hosp.*, 111 N.H. 276, 281 A.2d 589 (1971) (doctor acted in a manner that was disruptive to the hospital's nursing and administrative staff); *Ponca City Hosp. v. Murphree*, 545 P.2d 738 (Okla. 1976) (hospital personnel had extreme difficulty in working with Dr. Murphree); *Thompson v. Grays Harbor Community Hosp.*, 36 Wash. App. 300, 675 P.2d 239 (1983) (physician difficult in her behavior to hospital employees and exhibited displays of temper). *See also supra* note 20; *Eidelson v. Archer*, 645 P.2d

behavior to patients, yelling at them or refusing to listen to their legitimate questions and requests;²⁷ negative comments to patients about other physicians, nurses, or treatment being given the patient or the operation of the hospital;²⁸ threats or physical assaults on physicians, employees or others on hospital property.²⁹

When any one, or a combination, of such acts or words is repeated, the practitioner has stepped across the line which divides the occasional over-reaction to stress from a course of behavior inimical to the proper operation of the hospital. Many of the court decisions discussed in this article illustrate the particular kinds of behavior that have been held to be a reasonable basis upon which a hospital may take action. Before we can reach the question of when and in what ways the hospital can act, some discussion of the medical staff appointment process and the important role played by both corporate and medical staff bylaws is necessary.

III. HOSPITAL MEDICAL STAFF APPOINTMENT

In order to discuss this subject appropriately, it is first necessary to explore the nature of the unique relationship between the health care practitioner and the hospital. This relationship has evolved significantly in the recent past due to several—often competing—pressures on practitioners and hospitals.³⁰ Today, the hospi-

171 (Alaska 1982); *Akopianz v. Board of County Comm'rs of Otero County*, 65 N.M. 125, 333 P.2d 611 (1959); *Ritter v. Board of Comm'rs. of Adams County Pub. Hosp. Dist. No. 1*, 96 Wash. 2d 503, 637 P.2d 940 (1981) (en banc).

27. A recent case which poignantly illustrates such conduct is *Greer v. Medders*, ___ Ga. ___, 336 S.E.2d 328 (1985). In *Greer*, a physician made the following statements to a post-operative patient and his wife: "I don't have to be your damn doctor" and "If your smart ass wife would keep her mouth shut things wouldn't be so bad." *Id.* at 329. See also *Sosa v. Board of Managers of Val Verde Memorial Hosp.*, 437 F.2d 173 (5th Cir. 1971); *Pontius v. Children's Hosp.*, 552 F. Supp. 1352 (W.D. Pa. 1982); *McMillan v. Anchorage Community Hosp.*, 646 P.2d 857 (Alaska 1982); *Eidelson v. Archer*, 645 P.2d 171 (Alaska 1982); *Pick v. Santa Ana-Tustin Community Hosp.*, 130 Cal. App. 3d 970, 182 Cal. Rptr. 85 (1982).

28. See, e.g., *Silver v. Queen's Memorial Hosp.*, 63 Hawaii 430, 629 P.2d 1116 (1981) (whole scenario revolving around treatment and billing of a physician's patient without the attending physician's knowledge); *Siegal v. St. Vincent Charity Hosp. and Health Center*, No. 79376 (Cuyahoga County, Ohio Oct. 31, 1985) (physician made negative statements about the hospital to a patient who was also a hospital employee); *Thompson v. Grays Harbor Community Hosp.*, 36 Wash. App. 300, 675 P.2d 239 (1983) (referred to another physician as "a butcher").

29. See, e.g., *Robbins v. Ong*, 452 F. Supp. 110 (S.D. Ga. 1978).

30. For a discussion of the factors which have contributed to these competing pressures, see Springer, *The Conflicting Legal Pressures on the Modern Hospital*, 14 N.C. CENT. L.J. 82 (1983); see also P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE*

tal medical staff consists primarily of physicians and dentists, but other practitioners, especially podiatrists, nurse anesthetists and clinical psychologists, are being included with growing frequency.³¹ Only persons who have been appointed to the hospital's medical staff and who have been granted clinical privileges³² are authorized to admit or treat patients in the hospital. Most importantly, medical staff appointment is a privilege, not a right,³³ and no person has

(1982). For a related view, see R. STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* (1971).

31. See *supra* note 8. For several recent cases which evidence this evolution in the composition of the medical staff, see, e.g., *Bhan v. NME Hospitals, Inc.*, 772 F.2d 1467 (9th Cir. 1985) (nurse anesthetist permitted to bring an action alleging that hospital's policy of allowing only M.D. anesthesiologists to perform anesthesia services in the hospital's operating rooms violated federal antitrust laws); *Dooley v. Barberton Citizens Hosp.*, 11 Ohio St. 3d 216, 465 N.E.2d 58 (1984) (podiatrist successfully sued and was granted clinical privileges); compare *Fort Hamilton-Hughes Memorial Hosp. Center v. Southard*, 12 Ohio St. 3d 263, 466 N.E.2d 903 (1984) (court construed same statute as in *Dooley* but chiropractor was denied medical staff membership). See also COMMENTS OF THE BOSTON REGIONAL OFFICE OF THE F.T.C. (Dec. 14, 1984) (position paper sent to the Board of Registration in Medicine of the Commonwealth of Massachusetts which stated that, in the hospital setting, competition between nurse anesthetists and M.D. anesthesiologists for anesthesia services should be condoned and encouraged). See generally Horty, *Non-Physician Practitioners*, *HOSPITAL LAW* (Oct. 1985).

32. Appointment to a hospital's medical staff is actually a two step process: (a) appointment to the staff which is granted by a hospital's governing board only after a practitioner is able to satisfy certain specific criteria relating to licensure, education, training, background, experience, health, ethics etc.; see *JCAH, supra* note 3, at 10.1.2; Medicare Conditions of Participation, 42 C.F.R. § 405.1021(e)(1) (1983); and (b) the assignment of specific clinical privileges which the staff appointee has demonstrated he is currently competent to perform; see *JCAH, supra* note 3, at 10.4; Medicare Conditions of Participation, 42 C.F.R. § 405.1021(e)(3) (1983). Courts often fail to make this distinction and only serve to confuse the issue by making reference to "staff privileges."

33. A physician has no constitutional right to practice medicine in a public hospital. See, e.g., *Hayman v. City of Galveston*, 273 U.S. 414 (1927); *Klinge v. Lutheran Charities Ass'n. of St. Louis*, 523 F.2d 56 (8th Cir. 1975); *Woodbury v. McKinnon*, 447 F.2d 839 (5th Cir. 1971); *Foster v. Mobile County Hosp. Bd.*, 398 F.2d 227 (5th Cir. 1968); *Meredith v. Allen County War Memorial Hosp. Comm'n.*, 397 F.2d 33 (6th Cir. 1968); *Birnbaum v. Trussell*, 371 F.2d 672 (2nd Cir. 1966); *Duffield v. Memorial Hosp. Ass'n. of Charleston*, 361 F. Supp. 398 (S.D. W. Va. 1973), *aff'd*, 503 F.2d 512 (4th Cir. 1974).

"The ultimate decision as to whether a particular physician ought to enjoy staff-privileges at a hospital should be made by persons having the expertise necessary to make an intelligent decision, and not by judges. It is probably for such reason that '[h]ospital boards and officers are vested with a large measure of management discretion in the selection of members of the medical staff of a hospital.'" *Early v. Bristol Memorial Hosp., Inc.*, 508 F. Supp. 35, 38 (E.D. Tenn. 1980). See also *Moore v. Andalusia Hosp., Inc.*, 284 Ala. 259, 224 So. 2d 617 (1969); *Even v. Longmont United Hosp. Ass'n.*, 629 P.2d 1100 (Colo. Ct. App. 1981); *Hoffman v. Garden City Hospital-Osteopathic*, 115 Mich. App. 773, 321 N.W.2d 810 (1982); *Tigua Gen. Hosp., Inc. v. Feuerberg*, 645 S.W.2d 575 (Tex. Civ. App. 1983).

However, the modern trend appears to be in the direction of those jurisdictions which permit judicial review in order to ensure that the exclusion was in compliance with the hospital's medical staff bylaws and was not arbitrary, capricious or unreasonable. See *Feld-*

a right to be granted specific clinical privileges once appointed.³⁴

The appointment to a medical staff is made by the governing body of the hospital, almost always on the recommendation of the medical staff executive committee after an evaluation of the applicant practitioner's background, education, training, experience, ethics, health status, current competence and other information obtained from the practitioner and external sources.³⁵ The evalua-

man v. St. Mary's Hosp. and Health Center, 126 Ariz. 262, 614 P.2d 343 (1980); Avol v. Hawthorne Community Hosp., 135 Cal. App. 3d 101, 184 Cal. Rptr. 914 (1982); Dance v. North Broward Hosp. Dist., 420 So. 2d 315 (Fla. Dist. Ct. App. 1982); Silver v. Castle Memorial Hosp., 53 Hawaii 475, 497 P.2d 564 (1972); McElhinney v. William Booth Memorial Hosp., 544 S.W.2d 216 (Ky. 1976); Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 281 A.2d 589, *cert. denied*, 404 U.S. 995 (1971); Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963); Kelly v. St. Vincent Hosp., 102 N.M. 201, 692 P.2d 1350 (1984); Fritz v. Huntington Hosp., 39 N.Y.2d 339, 348 N.E.2d 547 (1976); Cameron v. New Hanover Memorial Hosp., Inc., 58 N.C. App. 414, 293 S.E.2d 901 (1982); Gotsis v. Lorain Community Hosp., 46 Ohio App. 2d 8, 345 N.E.2d 641 (1974); Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398 (1975); Woodard v. Porter Hosp., Inc., 125 Vt. 419, 217 A.2d 37 (1966). *See generally* Ey, *Cause of Action for Wrongful Termination of, or Refusal to Grant, Hospital Privileges*, 2 CAUSES OF ACTION 597 (1983); Annot., 37 A.L.R. 3d 645 (1971).

Of even greater importance is the recent application of the federal antitrust laws to decisions involving medical staff appointments and clinical privileges. *See, e.g.*, Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 105 S. Ct. 1777 (1985); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 459 U.S. 971 (1982). *See also* Miles & Philp, *Hospitals Caught in the Antitrust Net: An Overview*, 24 DUQ. L. REV. 489 (1986); Kissam, Webber, Bigus & Holzgrafe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CALIF. L. REV. 595 (1982).

34. "The mere fact that a person is admitted or licensed to practice his profession does not justify any inference beyond the conclusion that he has met the minimum requirements and possesses the minimum qualifications for that purpose Moreover not all professional men have a personality that enables them to work in harmony with others, and to inspire confidence in their fellows and in patients. These factors are of importance and here, too, there is room for selection." Shulman v. Washington Hosp. Center, 222 F. Supp. 59, 64 (D.D.C. 1963). *See also* Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398 (1975); JCAH, *supra* note 3, at 10.4.1.2.

35. Other acceptable medical staff appointment criteria include: (a) location within the geographic service area of the hospital as defined by the governing board, see 42 C.F.R. § 405.1021(h)(2); JCAH, *supra* note 3, 10.1.2.3.1.2.3.4 and 10.4.2.2.3.4; Sosa v. Board of Managers of Val Verde Memorial Hosp., 437 F.2d 173 (5th Cir. 1971); Kennedy v. St. Joseph Memorial Hosp. of Kokomo Indiana Inc., ___ Ind. App. ___, 482 N.E.2d 268 (1985); Berman v. Valley Hosp., 196 N.J. Super. 359, 482 A.2d 944 (1984); *compare* Sams v. Ohio Valley Gen. Hosp. Ass'n., 413 F.2d 826 (4th Cir. 1969); (b) possession of a current valid professional liability insurance policy in coverage amounts satisfactory to the hospital, see JCAH, *supra* note 3, 10.1.2.3.1.2.3.3 and 10.4.2.2.3.3; Musso v. Suriano, 586 F.2d 59 (7th Cir. 1978), *cert. denied*, 440 U.S. 971 (1979); Pollock v. Methodist Hosp., 392 F. Supp. 393 (E.D. La. 1975); Holmes v. Hoemako Hosp., 117 Ariz 403, 573 P.2d 477 (1977); Wilkinson v. Madera Community Hosp., 144 Cal. App. 3d 436, 192 Cal. Rptr. 593 (1983); Maxey v. Martin Memorial Hosp. Ass'n., Inc., No. 82-330-CA (Fla. Cir. Ct. May 24, 1983), *aff'd*, 449 So. 2d 275 (Fla. Dist. Ct. App. 1984); Renforth v. Fayette Memorial Hosp. Ass'n, 178 Ind. App. 475, 383 N.E.2d 368 (1978), *cert. denied*, 444 U.S. 930 (1979); Chalasani v. Neuman, 97 A.D.2d 806, 468 N.Y.S.2d 672 (1983); *compare* State of Kansas *ex rel* Schneider v. Liggett, 223 Kan. 610,

tion is performed by the medical staff leadership structure, consisting of the chiefs of clinical divisions in the hospital, the credentials committee and the executive committee. Periodic reappointment occurs in much the same fashion, except that the data upon which the executive committee makes its recommendation to the governing board come primarily from internal sources, because the practitioner should have established, by reappointment time, a "track record" in the hospital.³⁶ It will be remembered that the vast majority of practitioners on medical staffs are independent entrepreneurs—not employees of the hospital. Moreover, the hospital appointment, while a privilege, is nonetheless an important asset to the practitioner. Many practitioners seek to obtain as many hospital medical appointments as possible,³⁷ but this practice is growing increasingly difficult because of economic, competitive, technological and other constraints. Indeed, some hospital

576 P.2d 221 (1978); (c) certification by the appropriate medical specialty board, unless such requirement is waived by the hospital governing body after considering the special competence and experience of the applicant, see JCAH, *supra* note 3, 10.4.2.7.3.2; Sarasota County Pub. Hosp. Bd. v. Shahawy, 408 So. 2d 644 (Fla. Dist. Ct. App. 1981); and (d) the ability to document their background, experience and demonstrated clinical ability, see JCAH, *supra* note 3, at 10.4.2.5. See generally Harty, *Criteria for Initial Appointment*, MEDICAL STAFF LAW MANUAL (1984).

36. See JCAH, *supra* note 3, at 10.5; A.O.A., *supra* note 3, at 18; Medicare Conditions of Participation, 42 C.F.R. § 405.1021(e)(3) (1983).

37. For example, in *Rosner v. Eden Township Hosp. Dist.*, 58 Cal. 2d 592, 375 P.2d 431, 25 Cal. Rptr. 551 (1962), Dr. Rosner had privileges in approximately forty hospitals. Today, however, hospitals have been given discretion by the courts to institute "medical staff development policies" which will have the affect of limiting appointments to the medical staff for a specified period of time. If the policy is properly designed and reasonably related to patient care it will be upheld. See *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd.*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 459 U.S. 971 (1982); *Guerrero v. Burlington County Memorial Hosp.*, 70 N.J. 344, 360 A.2d 334 (1976); *Forcina v. Hackensack Medical Center*, No. C-1801-82 (N.J. Super. Ct. Mar. 6, 1984); *Davis v. Morristown Memorial Hosp.*, 106 N.J. Super. 33, 254 A.2d 125 (1969); JCAH, *supra* note 3, 10.4.2.2.3.1; *but compare Walsky v. Pascack Valley Hosp.*, 145 N.J. Super. 393, 367 A.2d 1204 (1976). See also Rev. Rul. 56-185, 1956-1 CB 202, which sets forth a four part test to be used in determining whether a hospital qualifies for an exemption from federal income tax under section 501(a) of the Internal Revenue Code of 1954 as an organization described in section 501(c)(3) thereof. The third prong of this four part test is as follows:

It (the hospital) must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to the exclusion of all other qualified doctors It is recognized, however, that in the operation of a hospital there must of necessity be some discretionary authority in the management to approve the qualifications of those applying for the use of the medical facilities. *The size and nature of facilities may also make it necessary to impose limitations on the extent to which they may be made available to all reputable and competent physicians in the area.*

Id. at 203 (emphasis added).

governing bodies have undertaken to institute medical staff development policies in order to obtain the most appropriate kinds of practitioners who will admit a favorable "patient mix" for the hospital's stability and survival.³⁸ Obviously, neither disruptive behavior nor inability to get along with others is likely to be a favored behavioral characteristic in terms of appointment to a medical staff that may be limited in numbers of general practitioners or specialists. Indeed, because of the increasing emphasis on the team approach in health care delivery, along with the decided trend toward hospital-practitioner and practitioner-practitioner joint ventures, the ability to cooperate with others is an important attribute of a health care professional.³⁹

The appointment/reappointment process is defined by law, generally, in the form of hospital licensing regulations⁴⁰ and national hospital standards,⁴¹ and by the hospital and medical staff bylaws.⁴² From all of these sources and a growing body of case law,

38. In *Forcina v. Hackensack Medical Center*, *supra* note 37, the Medical Center's Ad Hoc Blue Ribbon Committee on staffing stated:

Staffing has to depend on a decision as to what kind of hospital this is to be.

To survive and improve as an institution, we should consider the policy that department directors are to recruit carefully and earnestly instead of waiting for applicants to file. This includes the needs for areas to be developed to meet the needs of a changing and aging community. Recruiting is needed to meet the needs of a teaching hospital, and we have to concentrate on developing excellence in teaching and skills in established areas and to develop services that are needed. This would be competitive with other hospitals rather than with the existing staff.

Id. at 24. The court then found that the hospital's decision which denied appointment to Dr. Forcina "was related to the Hospital's policy of shifting from a normal community hospital to a teaching hospital and regional center, which is both in the interest of the community and the hospital based on this record." *Id.* at 27. See also Burik and Duvall, *Hospital Cost Accounting: Strategic Considerations*, 15 HEALTHCARE FINANCIAL MANAGEMENT 19 (Feb. 1985); Capor and Zubkof, *Managing Medical Costs through Small Area Analysis*, BUSINESS AND HEALTH (Sept. 1984); Plomann, Bisbee and Esmond, *Use of Case Mix Information in Hospital Management: An Overview and Case Study*, 14 HEALTHCARE FINANCIAL MANAGEMENT 28 (Oct. 1984); Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, 3 HEALTH AFFAIRS 6 (Summer 1984).

39. STARR, *supra* note 30, at 26.

40. See, e.g., FLA. ADMIN. CODE 10D-28.58 (1984); N.Y. ADMIN. CODE tit. 10, § 405.1023(d) (1977); 28 PA. ADMIN. CODE § 107.5 (Shepard's 1983); WASH. ADMIN. CODE R. 248-18-030 (1983).

41. See *supra* notes 35 & 36.

42. The hospital governing body is charged with the responsibility of adopting the hospital's corporate bylaws, see JCAH, *supra* note 3, at 4.1.1; A.O.A., *supra* note 3, at 8; 42 C.F.R. § 405.1021(a) (1983). The governing body also approves the hospital's medical staff bylaws, see JCAH, *supra* note 3, at 4.1.18.1 and 10.2.1; A.O.A., *supra* note 3, at 15; 42 C.F.R. § 405.1023 (1983). This dual system of bylaws is an anachronism of the past when the medical staff was dominant within the hospital. While this view of the medical staff is no longer

the clear fact emerges that the hospital, acting through its governing body, must wisely and carefully select the medical staff. The failure to do so may lead to liability.⁴³ Similarly, the failure to appropriately grant clinical privileges will also lead to hospital liability.⁴⁴ The appointment and clinical privileges decision is a most serious one with very important consequences to the hospital, to other practitioners, and, most assuredly, to patients.

Interestingly, some courts have recognized the powerful effect a medical staff appointment may have not only on hospital personnel and the health care community, but also on the general public.⁴⁵ Although the Supreme Court of Washington in *Pedroza v. Bryant*,⁴⁶ denied hospital liability for the negligence of a staff appointee in his private office, the court did accept the idea that the hospital, by its appointment, makes a public statement about the practitioner's qualifications. If it knows or learns of something because of that relationship, it may have a duty to act even when the practitioner is performing services to his private patients in his private office.⁴⁷

From this brief discussion it should be clear that the hospital appointment and reappointment decision is significant. It carries with it certain legal and ethical implications. The hospital is at risk for its failure to properly certify practitioners' credentials.

IV. LAYING A GOOD FOUNDATION: BYLAWS

Before addressing bylaws, it is important to note that hospitals are like all other corporations. The ultimate responsibility for the corporation's conduct rests with the governing board. As a result, a hospital governing board has the implicit corporate authority to act in cases of disruption in order to fulfill its purpose of providing

accurate, see, e.g., *Weiss*, 745 F.2d 786, the JCAH, A.O.A., and Medicare Conditions of Participation have all retained the requirement of two sets of bylaws.

43. See cases cited *supra* notes 6 & 7.

44. *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972); *Gonzales v. Nork and Mercy Hosps. of Sacramento*, No. 228566 (Sacramento Super. Ct. Nov. 19, 1973).

45. "Without regard to the absence of any legal liability, the hospital in admitting a physician or surgeon to its facilities extends a moral imprimatur to him in the eyes of the public." *Shulman v. Washington Hosp. Center*, 222 F. Supp. 59, 64 (D.D.C. 1963) (quoted in *Huffaker v. Bailey*, 273 Or. 273, 277, 540 P.2d 1398, 1402 (1975)). See also *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 104 S. Ct. 1551, 1575 (1984) (O'Connor, J., concurring).

46. 101 Wash. 2d 226, 677 P.2d 166 (1984).

47. "Acts of malpractice committed by a staff physician outside the hospital are relevant only if the hospital has actual or constructive notice of them, and where failure to take some action as a result of such notice is negligence." *Id.* at 235, 677 P.2d at 172. See also *Fridena v. Evans*, 127 Ariz. 516, 622 P.2d 463 (1980).

quality medical and hospital care in an atmosphere conducive to it.⁴⁸ The board may act, therefore, even without language in its by-laws specifying that staff appointments are conditional on the cooperation and proper behavior of the appointees. Well-drafted by-laws, however, serve many important functions. Because of the emphasis which courts place upon these provisions,⁴⁹ good language will be very helpful in making a court aware of the flexibility that is necessary for hospital management to deal appropriately with the infinitely variable ways practitioners manifest disruptive behavior.⁵⁰ In addition, carefully drafted bylaws will serve the more important purpose of informing all medical staff appointees that "ability to work with others" is a criterion they are required to meet to be eligible for initial medical staff appointment and for continued appointment. The hospital should place appropriate language in both the corporate bylaws and those of the medical staff.

A. *Corporate Bylaws*

When dealing with disruptive physicians, the "reality" of the hospital experience leads to the conclusion that disciplinary action for disruptive behavior more properly rests with the board and management than with the medical staff. Frequently, incidents and manifestations of the problem are experienced most directly and continually by hospital personnel, not other physicians.

By reason of their specialties or their schedules, many physicians on the medical staff do not regularly encounter their colleagues in day-to-day practice in the hospital. Furthermore, if the intolerable conduct is directed primarily at nurses or other hospital personnel,

48. "An organized governing body, or designated persons so functioning is responsible for establishing policy, maintaining quality patient care, and providing for institutional management and planning." JCAH, *supra* note 3, at 4.1; *see also* A.O.A., *supra* note 3, at 8; Medicare Conditions of Participation, 42 C.F.R. § 405.1021 (1983).

49. *See infra* notes 61-69, 89-94 and accompanying text.

50. Perhaps in no other field are bylaws so important, yet so cavalierly treated. Hospital management, medical staff leadership, even hospital counsel, are often insensitive to the point of obliviousness to the necessity of careful drafting of hospital and medical staff by-laws and other documents. Courts look to the bylaws to determine hospital policy and procedures. All too often those documents are mere "cut and paste jobs" performed without thought or analysis.

The medical staff is an integral part of the hospital. *See, e.g., Weiss*, 745 F.2d 786, and *Johnson*, 301 N.W.2d 156. Inartfully drafted medical staff bylaws may give the impression that the medical staff is a separate entity from the hospital. Such an impression is legally incorrect and may create a risk of legal liability. *See Bhatt v. Uniontown Hosp., C.A. No. 83-2455 (W.D. Pa. Jan. 27, 1984); Harty, The Legal Status of the Medical Staff, ACTION-KIT FOR HOSPITAL LAW (Jan. 1984).*

other medical staff appointees may be personally unaware of it. Because the rest of the medical staff does not see and feel the effects itself, it is often blind or indifferent to its seriousness. As a result, it does not act, or procrastinates or minimizes the problem, which heightens the effect with respect to hospital personnel.

Even where the behavior affects other physicians, the medical staff structure may not be the ideal vehicle for dealing with it. For one thing, those who are not personally affected may see it as nothing but a "personality conflict" and may not wish to deal with it for fear of setting a precedent of conduct for other of their peers or themselves.⁵¹ On the other hand, it may in fact be a matter between two physicians, in which case there is danger that supporters will rally behind each and turn a disciplinary matter into a power struggle. Furthermore, in addition to their vulnerability to counter-attacks or a change in referral patterns, there is a reluctance to act on the part of physicians which stems from their view of their relationship to the hospital as purely individual without a sense of identification with hospital operation. If the issue is not one of clinical competence, it is not, in their view, any of their business. For any and all of these reasons, if discipline is left only to the medical staff, it may never occur, or may be undertaken in a highly charged atmosphere which is unduly traumatic and virtually invites litigation.

The hospital should exercise jurisdiction over these matters and can do so by providing the initiative and the appropriate procedures in its own bylaws. This focuses attention on the problem where it is being felt, in the management and employees. The board will relieve the medical staff of a responsibility for which it has neither the taste nor the experience, and will give recognition to the fact that the problem is one between the hospital and the individual physician, not between the physician and his colleagues.

The board's involvement in disciplinary matters also makes it apparent to hospital employees that the board is aware of its obligation to run an efficient and effective hospital. This does not preclude the medical staff from making a recommendation to the board, but clearly provides the hospital the option to assume control in a situation in which the medical staff is reluctant to take action. When a physician understands that he is accountable directly to the board for his personal conduct or behavior, the hospital may have less difficulty in changing behavior in an informal

51. See *supra* note 9 and accompanying text.

way than when the physician perceives that he would be bending to the wishes of his colleagues in matters that he considers none of their business.

Therefore, to give the hospital appropriate tools, the following language should be included in the hospital's corporate bylaws:

The Board shall appoint a medical staff operating in accordance with these bylaws and those bylaws of the medical staff approved by the Board. The medical staff shall operate as an integral part of the hospital corporation and, through its department chairmen, committees and officers, shall be responsible and accountable to the Board for the discharge of those duties and responsibilities delegated to it by the Board from time to time. The Board specifically reserves the authority to take any direct action it deems appropriate with respect to any individual appointed to the medical staff or given clinical privileges or the right to practice in the hospital. Action taken by the Board in such matters may, but need not, follow the procedures outlined in the medical staff bylaws. Any Board action that would result in a reduction of clinical privileges, suspension of clinical privileges for a month or more, revocation of staff appointment or denial of reappointment shall entitle the affected individual to a hearing and appeal as outlined in the medical staff bylaws except that (a) the members of the Hearing Panel shall be appointed by the Chairman of the Board and (b) at the conclusion of the hearing, the Committee's recommendation and report shall be sent directly to the Board.

B. *Medical Staff Bylaws*

Although it should not be burdened with the primary responsibility for dealing with disruptive behavior, the medical staff should also be delegated authority for undertaking disciplinary action in these matters. This delegation is in addition to the hospital's ability to act in the absence of a medical staff committee recommendation.

Most significantly, the hospital must be sure that the medical staff bylaws do not contain any language which narrowly limits the grounds for suspension or termination, or a refusal to appoint. Narrowly written bylaw provisions may prejudice the hospital's ability to terminate a physician for conduct which would, in the absence of such self-limiting language, be a proper and legally supportable basis for taking action.⁵² The following language should

52. See, e.g., *Miller v. Eisenhower Medical Center*, *infra* notes 61-69 and accompanying text (in addition to proof of disruptive behavior, bylaw provision was interpreted to also require proof of a direct negative effect on patient care); *McElhinney v. William Booth Memorial Hosp.*, *infra* notes 89-94 and accompanying text (bylaw provision requiring "gross" conduct narrowly interpreted).

be placed in the medical staff bylaws under "Qualifications for Appointment" to ensure that medical staff leadership has the proper tools to take action:

Appointment to the medical staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these bylaws and in such policies as are adopted from time to time by the Board. Only physicians and oral surgeons (and podiatrists) who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation and character and their ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them in the hospital will receive quality care and that the hospital and its medical staff will be able to operate in an orderly manner shall be qualified for appointment to the medical staff. The word "character" is intended to include the applicant's mental and emotional stability.

V. WHEN CAN THE HOSPITAL ACT?

A. *Denial of Initial Appointment to the Medical Staff*

A hospital is not obligated to appoint to its medical staff a practitioner who has evidenced patterns of disruptive behavior at other hospitals or during the course of his medical training, either in medical school or as an intern or resident. In this regard, a record of disruptive conduct is no different from a record of substandard clinical performance. The hospital has both the right and the duty to assure itself that new appointees to the medical staff will meet its standards of both professional performance and personal conduct, so long as these standards are reasonably related to the hospital's goals of providing quality medical care and efficient hospital operation.⁵³ If the hospital has evidence of, or reasonable doubts about an applicant's prior conduct, the applicant has the burden of demonstrating to the hospital's satisfaction that his behavior, as well as his professional performance, will comport with the hospital's standards.

Denial of staff appointment based on negative reference letters or evaluations has been upheld by the courts. Illustrative of such decisions is the case of *Pick v. Santa Ana-Tustin Community Hospital*.⁵⁴ Dr. Jan Pick applied for medical staff appointment in the defendant hospital's psychiatric department. Dr. Pick was denied

53. The idea discussed, *supra* note 45, that the hospital places its "imprimatur" upon its staff physicians is an important one. As stated in *Shulman*, 222 F. Supp. at 64, "there is room for selection."

54. 130 Cal. App. 3d 970, 182 Cal. Rptr. 85 (1982).

appointment on the basis that his "manifested personality would create and present a real and substantial danger to the high quality of medical care both to his patients as well as other physicians' patients" ⁵⁵

A major reason for the adverse action by the hospital was the negative tone of the letters of reference from Dr. Pick's former colleagues. The hospital had communicated with the various institutions with which Dr. Pick had been associated, requesting information about him. The replies disclosed that almost invariably Dr. Pick had had difficulty in his dealings with his colleagues and the personnel of the institutions with which he had been associated. Specifically, the director of the hospital at which Dr. Pick had completed his internship stated in a letter that "[h]e did have some difficulty in his interpersonal relationships particularly in his response to criticism, ability to work with others, and leadership." ⁵⁶ The chief of professional education of a hospital at which Dr. Pick had been a resident for two years, stated that Dr. Pick "performed satisfactorily as a resident but had some personality problems which interfered with his relationship with staff and colleagues. By mutual agreement he transferred to another program for his third year of training." ⁵⁷ Finally, in two evaluations from hospitals at which Dr. Pick had had privileges, he was rated "below average" with respect to the factors of emotional stability and control and professional relations with patients.

Based on this evidence, as well as that of specific incidents in which Dr. Pick had caused problems, the California Court of Appeals found that he had not met his "burden of establishing his ability to work with others in a hospital setting in a manner that would assure that high quality medical care would be furnished patients at the hospital." ⁵⁸ Thus, the hospital's denial of appointment was upheld. ⁵⁹

55. *Id.* at 975, 182 Cal. Rptr. at 88.

56. *Id.* at 980, 182 Cal. Rptr. at 92.

57. *Id.* at 981, 182 Cal. Rptr. at 92.

58. *Id.* at 983, 182 Cal. Rptr. at 93-94.

59. For other cases in which courts have upheld a hospital's denial of initial appointment because of disruptive behavior of the applicant, see *Laje v. R.E. Thomason Gen. Hosp.*, 564 F.2d 1159 (5th Cir. 1977); *Sosa v. Board of Managers of Val Verde Memorial Hosp.*, 437 F.2d 173 (5th Cir. 1971); *Dunbar v. Hospital Auth. of Gwinnett County*, 227 Ga. 534, 182 S.E.2d 89 (1971); *Silver v. Queen's Hosp.*, 63 Hawaii 430, 629 P.2d 1116 (1981); *Ladenheim v. Union County Hosp. Dist.*, 76 Ill. App. 3d 90, 394 N.E.2d 770 (1979); *Sussman v. Overlook Hosp. Ass'n.*, 95 N.J. Super. 418, 231 A.2d 389 (1967); *Theissen v. Watonga Municipal Hosp. Bd.*, 550 P.2d 938 (Okla. 1976); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398 (1975); *Hagen v. Osteopathic Gen. Hosp. of Rhode Island*, 102 R.I. 717, 232 A.2d 596

The hospital must not only have reasonable criteria for appointment,⁶⁰ but it must also apply those criteria appropriately. In *Miller v. Eisenhower Medical Center*,⁶¹ the California Supreme Court upheld a hospital medical staff bylaws provision which required applicants to document “*their ability to work with others, with sufficient adequacy to assure the Medical Staff and the Board of Trustees that any patient treated by them in the hospital will be given a high quality of medical care . . .*”⁶² The court disapproved, however, of the specific application of this bylaw in Dr. Miller’s case. Dr. Miller, a board certified family practitioner, applied for appointment to Eisenhower Medical Center. With his application, he submitted the names of twenty-five physicians who could be contacted for recommendations. Letters were sent to all twenty-five, many of whom responded.

On the basis of the comments received, the executive committee of the medical staff made a recommendation to the hospital board that Dr. Miller be denied appointment. Dr. Miller duly requested a hearing. At the hearing, a representative for the medical staff executive committee reported that there was no question about Dr. Miller’s professional capabilities or his competence as a physician, “but that the committee felt that [he] ‘came up wanting’ with respect to the opinions received on the question whether he would be an asset to the medical staff.”⁶³ Four physicians testified on Dr. Miller’s behalf. Although each was of the opinion that he would be an asset to the medical staff, when asked about his “interpersonal” relationships, their answers indicated that there might be a problem.

Ultimately, the hospital hearing panel upheld the medical staff executive committee’s recommendation to deny appointment, based upon the determination that sufficient doubt existed con-

(1967); *Rao v. Auburn Gen. Hosp.*, 19 Wash. App. 124, 573 P.2d 834 (1978).

60. See Medicare Conditions of Participation, 42 C.F.R. § 405.1021(e)(3) (1983); JCAH, *supra* note 3, at 10.1.2; A.O.A., *supra* note 3, at 15.

61. 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980).

62. *Id.* at 621 n.5, 614 P.2d at 261 n.5, 166 Cal. Rptr. at 829 n.5 (emphasis in original).

63. *Id.* at 621, 614 P.2d at 261, 166 Cal. Rptr. at 829. The court noted that out of 22 responses to the question of whether Dr. Miller would be an asset to the medical staff: [A]pproximately 15 were favorable, some enthusiastically so. Of the seven remaining responses, four were clearly unfavorable. Two of these answered simply: “No.” One answered: “Very controversial person. Has been disruptive in other situations.” One answered: “I have no knowledge of Dr. Miller’s plans regarding [Eisenhower Medical Center]. I do have knowledge of several physicians whose feelings are that they would think not.”

Id. at n.4.

cerning Dr. Miller's ability to work with others as required by the medical staff bylaws.

Dr. Miller appealed to the hospital board. At this appellate review, two additional physicians testified that:

[Dr. Miller] . . . had a reputation for getting along poorly with his colleagues. One stated that he "creates dissension" and "has relatively few friends in the community," the other that he "does not get along with most members of the medical community." Neither, however, indicated that he had personally had any difficulty working together with plaintiff in the care of patients.⁶⁴

The board affirmed the recommendation of the medical staff executive committee and denied Dr. Miller's application for appointment. Dr. Miller then sought to compel the hospital to appoint him to the staff via the court system. The trial court denied his petition. Dr. Miller appealed.

One of Dr. Miller's arguments was that the bylaws provision was "so vague and uncertain as to provide a substantial danger of arbitrary or discriminatory application, and that it must therefore be held invalid."⁶⁵ The California Supreme Court disagreed. It upheld the bylaw provision, noting:

It cannot be denied that the providing of high quality patient care is, quite properly, the primary concern of all hospital institutions. The governing authority bears the responsibility for assuring that this goal is achieved to the greatest extent possible, and its decisions relating to medical staff must take into account all factors which have a legitimate relationship to it. We are not prepared to say that an applicant's ability to work with other medical personnel in the hospital setting may not have a clear effect on the level of patient care provided.⁶⁶

After making the bylaw determination, however, the California high court narrowly interpreted the bylaw provision by requiring a direct nexus between the disruptive behavior and patient safety:

[The bylaw here at issue] must be read to demand a showing, in cases of rejection on this ground, that an applicant's inability to "work with others" in the hospital setting is such as to present a real and substantial danger that patients treated by him might receive other than a "high quality of medical care" at the facility if he were admitted to membership.⁶⁷

The court gave the hospital the option of appointing Dr. Miller to its staff or conducting "further administrative proceedings directed

64. *Id.* at 622, 614 P.2d at 262, 166 Cal. Rptr. at 830.

65. *Id.* at 626, 614 P.2d at 265, 166 Cal. Rptr. at 833.

66. *Id.* at 628, 614 P.2d at 267, 166 Cal. Rptr. at 835.

67. *Id.*

to the assessment of plaintiff's qualifications for admission to its medical staff *in light of a proper interpretation of its standards.*"⁶⁸ The *Miller* decision highlights the paramount importance of careful bylaws drafting.⁶⁹ Courts, like *Miller*, may narrowly construe such language and consequently overly restrict the ability of the medical staff leadership and governing body to properly handle practitioners whose inappropriate behavior may disrupt the orderly management of the hospital. Most courts, however, have applied a less strict interpretation of bylaws language.

In *Hagan v. Osteopathic General Hospital of Rhode Island*,⁷⁰ a physician who was denied appointment to the staff of the hospital at which he completed his internship sought a court order compelling the hospital to appoint him. Although the trial court conducted a thorough evidentiary hearing, it ultimately decided that, because the hospital was a private corporation, its decision was not subject to judicial review and dismissed the complaint. The physician appealed.

On review, the Supreme Court of Rhode Island elected to consider the doctor's chances of success on the merits. If he had none, it would not be necessary for the court to rule on the question of whether the court had the power of judicial review. The physician's principal contention was that the hospital decision was arbitrary, capricious and unreasonable. The trial court found that the defendant trustees had rejected the plaintiff's several applications for appointment because of a personality clash with the hospital administrator, because it appointed another physician, and because the trustees felt that the plaintiff might be a potential disruptive force in the hospital. In reviewing and upholding that determination, the supreme court held:

The record is replete with evidence of incidents involving personality clashes from which the trial justice could draw the inference that the Trustees were motivated in their decision on each application by a desire to avoid the creation of a hospital ambience not conducive to the best interests of the sick and injured for whose welfare the hospital existed.

. . . .

68. *Id.* at 636, 614 P.2d at 271, 166 Cal. Rptr. at 839 (emphasis added). However, Eisenhower Medical Center never had to make the choice. As reported in a California newspaper, Dr. Miller was sentenced to 25 years in prison for conspiring to murder his wife. *Miller Ruled Guilty of Plotting Murder*, PALM SPRINGS DESERT SUN, April 23, 1980, § 1, at 1, col. 1.

69. Compare quoted text accompanying *supra* note 62 with suggested bylaw provision in text following *supra* note 52.

70. 102 R.I. 717, 232 A.2d 596 (1967).

When the motivating circumstances of a decision made to achieve a valid purpose bear a reasonable relationship to the purpose intended to be achieved by the decision, such decision will not be disturbed by the courts as being arbitrary, capricious or unreasonable within the meaning of the equal protection guarantee.⁷¹

Similarly, in *Laje v. R.E. Thomason General Hospital*,⁷² the Fifth Circuit Court of Appeals upheld a denial of initial appointment. In that case, the hospital refused to appoint a psychiatrist on the grounds of incompetence and insubordination. The physician had been employed by the hospital as clinical director of psychiatry but was summarily discharged for "insubordination" with eleven months remaining on his contract of employment. He then applied for appointment to the staff, but the hospital postponed definitive action on his request and refused to give him a hearing. Dr. Laje obtained an order from the federal district court directing the hospital board to provide him a hearing.

At the hearing, allegations of both incompetence and insubordination were considered. On the insubordination issue, there was testimony to the effect that the doctor had refused to cooperate in treating drug addicts, had employed restraints in violation of hospital policy, and had been unable to get along with the medical director. After the hospital board decided to deny his application, the physician returned to court. The district court held that the board's decision was not supported by substantial evidence and ordered the hospital to appoint him, but the order was stayed pending the hospital's appeal.

When the circuit court reviewed the record, it reversed the district court, saying:

As for the substantiality of the evidence upon which the board's adverse decision was based, we find that the record contains sufficient evidence to support the denial of privileges. The evidence presented at the hearing related to the level of Dr. Laje's professional competence and his ability to function smoothly in the hospital setting. Thus, the board complied with this Court's guideline . . . that "in exercising its broad discretion the board must refuse staff applicants only for those matters which are reasonably related to the operation of the hospital."⁷³

Once again, an appellate court recognized smooth working relationships as a proper, and enforceable, requirement of medical staff appointees.

71. *Id.* at 726, 232 A.2d at 601-02.

72. 564 F.2d 1159 (5th Cir. 1977).

73. *Id.* at 1162.

The Washington Court of Appeals also reached a similar conclusion in *Rao v. Auburn General Hospital*.⁷⁴ Although the factual basis upon which Dr. Rao's requests for appointment was denied is not set forth in the court's opinion in detail, a footnote⁷⁵ indicates that her "personality" played some part in the decision. The court held that:

In its own interest and in the public interest, a hospital does have the discretionary right to exclude doctors from staff privileges, whether based on the doctor's lack of proficiency or upon the concern that the doctor has a personality which will be detrimental to the working of the hospital.⁷⁶

These judicial decisions recognize that if there is evidence that a practitioner's behavior might impede the orderly operation of the hospital or affect the proper discharge of his responsibilities to the hospital or to his patients, the hospital may deny his initial application for appointment to the medical staff regardless of his technical medical competence. The criterion which addresses the harmony of the organization is a valid one. Thus, the practitioner-applicant who has a *track record* of disruptiveness can be denied.

B. Denial of Reappointment to the Medical Staff

Every court which has reviewed a hospital's denial of reappointment due to the physician's disruptive behavior has found such misconduct to be a sufficient basis for the decision not to reappoint. In *Ladenheim v. Union County Hospital District*,⁷⁷ the medical staff of a public hospital recommended approval of Dr. Ladenheim's reappointment, even though he had exhibited uncooperative behavior in the past. The board of directors refused to accept the recommendation and decided not to reappoint him. Dr. Ladenheim sued and obtained a restraining order, giving him access to the hospital's facilities until the hospital held a hearing to determine his eligibility for reappointment.

Prior to the hearing, plaintiff received a five-page notice of hearing which set forth sixteen general charges of unprofessional conduct and listed twenty-one separate incidents which formed the basis for the charges. At the hearing, the charges were substantiated by evidence which the court summarized in these words:

After hearing the evidence, the Credentials Committee [who acted as the

74. 19 Wash. App. 124, 573 P.2d 834 (1978).

75. *Id.* at 128 n.1, 573 P.2d at 837 n.1.

76. *Id.* at 127, 573 P.2d at 836.

77. 76 Ill. App. 3d 90, 394 N.E.2d 770 (1979).

hearing panel] concluded that the following allegations were true:

In August, 1976, during a dispute over administrative procedures, [Dr. Ladenheim] told a physical therapist that she had body odor and repeated the conversation to two other hospital employees.

In March, 1976, after receiving a bill for laboratory work done on a patient not sufficiently identified to allow direct billing of the patient, [Dr. Ladenheim] returned the bill with a note indicating that the business office staff was stupid.

In January, 1976, [he] refused to admit a patient to Union County Hospital, telling a relative of the patient that he was "mad at the hospital."

[He] refused to complete a medical planning form titled "Discharge Planning" on a nursing home patient, writing "you dreamer" across the space provided for his in-put.

On several occasions [he] made disparaging remarks to or refused to work with a particular nurse, and in one instance told her that an emergency room patient could go to another hospital "or go to hell" as far as he was concerned, because the patient was receiving medical assistance from welfare.

[He] refused to bring his criticisms of the nursing staff to the director of nursing, circumventing her entirely in favor of complaining to the hospital administrator. In addition, he indicated to another staff member that it was useless to request the nursing director's assistance, because she would not take any action.

In June of 1975 and in February of 1976, [he] refused nurses' requests to come to the emergency room to attend patients. He left standing orders that no nurse was to institute cardio-pulmonary resuscitation on any of his patients until receiving orders from him or another doctor.⁷⁸

When faced with that array of incidents and evidence, the credentials committee voted to recommend against reappointing Dr. Ladenheim. Appeals to the hospital's joint conference committee, the full medical staff, the board of directors, and the Union County Circuit Court of Appeals followed and failed.

The latter court's conclusion strongly endorsed the hospital's decision as having a valid basis in the evidence:

[T]he record is replete with evidence of appellant's inability to work effectively with other members of the hospital staff, and it is apparent that this personality problem was the principle (sic) issue before the Credentials Committee. . . . Clearly, appellant's inability to work with other members of the hospital staff was in itself sufficient grounds to deny him staff privileges.

. . . [W]e believe that a rational connection exists between the hearing and review provisions of the Bylaws, which were followed and afforded to appellant, and the Hospital District's insurance of professional and ethical qualifications of the staff physicians for the good of both the hospital and

78. *Id.* at 93-94, 394 N.E.2d at 772-73.

its patients.⁷⁹

In *Robbins v. Ong*,⁸⁰ the hospital denied Dr. Robbins' reappointment because of his disruptive behavior. Dr. Robbins' conduct included throwing a scrub brush outside the operating room, abusive shouting, interruption of a nurses' training session, verbal attacks on hospital employees, and disregard for hospital policy. Dr. Robbins asked the court to grant an injunction to restrain the hospital from revoking or refusing to renew his privileges. In its opinion denying Dr. Robbins' request, the federal district court described the personality of the disruptive physician and the position of the courts in these cases as follows:

At the hearing before this Court, patients of the plaintiff and physicians attested to his ability as a doctor. His competence is not in issue. What is in issue is the turmoil and disruption he has brought to the Liberty County Hospital for years. Apparently he is imbued with the idea that where Dr. Robbins sits, there is the head of the table. Rules are for others, not him. The trouble with this conception is that the Hospital is a public institution, not his private domain. It is operated by the Authority, a thought which he apparently cannot tolerate.

Personalities are at the heart of the problem. . . . It is for the Authority to decide whether personality differences are detrimental to the efficient operation of the hospital. This Court should not substitute its evaluation for that of the authority.⁸¹

In *Yarnell v. Sisters of St. Francis Health Services, Inc.*,⁸² the Indiana Court of Appeals reaffirmed that disruptive behavior is a sufficient reason to exclude a physician from a hospital, and that the governing board of the hospital is ultimately responsible for the medical staff appointment process.

Specifically, in January 1981, the medical board (the equivalent of the medical staff executive committee in other hospitals) recommended that Dr. Yarnell, an anesthesiologist, not be reappointed to the staff. A hearing was held according to the bylaws. The hearing committee recommended that Dr. Yarnell be reappointed. The medical board then changed its recommendation and also recommended to the governing board that Dr. Yarnell be reappointed. The administrator and executive director opposed Dr. Yarnell's reappointment because he was threatening and abusive to medical staff personnel and was generally disruptive of hospital procedures.

79. *Id.* at 98, 394 N.E.2d at 776.

80. 452 F. Supp. 110 (S.D. Ga. 1978).

81. *Id.* at 115.

82. — Ind. App. —, 446 N.E.2d 359 (1983).

After receiving this information, the governing board notified Dr. Yarnell that another hearing would be held.

Before the second hearing could be held, Dr. Yarnell sued asking the court to enjoin the hospital from relieving him of his staff appointment and subjecting him to the hearing. The trial court dismissed the suit. Dr. Yarnell appealed. Dr. Yarnell argued on appeal that the governing board was bound by the medical board's favorable recommendation because of a bylaws provision which stated that once a recommendation was received from the medical board, "*the Governing Board shall appoint*" the individual with specific privileges.⁸³ The court disagreed, stating:

Even though the Governing Board has delegated some of its authority, it still remains ultimately responsible for the efficient operation of the Hospital and maintenance of high standards of professional care imposed by the Hospital bylaws and statute.⁸⁴

The court also disagreed with Dr. Yarnell's contention that the administrator and executive director had acted with prejudice or malice toward him. The court found that they were merely carrying out their duties on behalf of the hospital. On the other hand, the court noted that the evidence indicated that Dr. Yarnell was a disruptive physician and was unable to work with others. This provided the hospital sufficient reason to deny him staff privileges. The Yarnell decision is especially important because it reaffirms the authority of the governing board, and it specifically endorses the involvement of hospital management in the reappointment process.

The New Hampshire Supreme Court also upheld a denial of reappointment based upon trial court findings that Dr. Bricker had been "a disruptive force" in the hospital. In *Bricker v. Sceva Speare Memorial Hospital*,⁸⁵ the supreme court held that the hos-

83. *Id.* at ___, 446 N.E.2d at 361.

84. *Id.* at ___, 446 N.E.2d at 362-63.

85. 111 N.H. 276, 281 A.2d 589, *cert. denied*, 404 U.S. 995 (1971). It is noted that many of these practitioners are quite litigious. Among the most litigious was Dr. Glenn Bricker, whose final review before the New Hampshire Supreme Court, in *Bricker v. Crane*, caused the court to note "[t]his case is the most recent skirmish in a long legal combat which threatens to become a modern *Jarndyce v. Jarndyce*, C. Dickens, *Bleak House passim* (1853)." 118 N.H. 249, 249, 387 A.2d 321, 321 (1978). This list includes: *Bricker v. Sceva Speare Memorial Hosp.*, 115 N.H. 709, 350 A.2d 623 (1975); *Bricker v. Sceva Speare Memorial Hosp.*, 114 N.H. 229, 317 A.2d 563 (1974), *cert. denied*, 410 U.S. 930 (1973); *Bricker v. Sceva Speare Memorial Hosp.*, 339 F. Supp. 234 (D.N.H. 1972), *aff'd*, *Bricker v. Crane*, 468 F.2d 1228 (1st Cir. 1972), *cert. denied*, 410 U.S. 930 (1973); *Bricker v. Sceva Speare Memorial Hosp.*, 111 N.H. 276, 281 A.2d 589, *cert. denied*, 404 U.S. 995 (1971); *Bricker v. Sceva Speare Memorial Hosp.*, 110 N.H. 412, 270 A.2d 358 (1970), *cert. denied*, 404 U.S. 995

pital board's decision was justified. The decision was necessary in order to preserve and protect the hospital, in light of its duty to maintain the hospital for service to all the public.

It is clear that the disruptive practitioner—albeit otherwise competent—has no more reason than the medically incompetent practitioner to assume that he will be automatically reappointed to the hospital medical staff. The hospital board may, and indeed should, consider and act upon a pattern or patterns of unacceptable behavior when it makes its determination as to reappointment. The medical staff leadership should not be diffident about applying behavioral criteria in its evaluation process preparatory to making recommendations to the governing body.

C. Dealing with Disruptive Behavior During the Practitioner's Term of Appointment

1. Necessity for Immediate Action

A somewhat more difficult question arises when the issue is the course to follow when the disruptive behavior occurs during the term of appointment and is of such a nature or degree of severity that it is not appropriate to wait until the end of the term to take action.

Personal conduct, no less than clinical performance, may pose such a threat to the safety and well-being of patients and the efficient operation of the hospital itself as to warrant the imposition of immediate action. There is no sound reason to distinguish between poor clinical performance and poor conduct or behavior in taking action during the term of a practitioner's appointment. Indeed, there is no question that, given supporting evidence, medical staff appointments and clinical privileges may be terminated during the term of appointment.⁸⁶ In *Grodjesk v. Jersey City Medical Center*,⁸⁷ disruptive behavior was held to be a valid basis for the termination of two oral surgeons in a hospital emergency room ro-

(1971). Other litigious physicians have included Dr. Charumati Rao: *Rao v. Auburn Gen. Hosp.*, 19 Wash. App. 124, 573 P.2d 834 (1978); *Rao v. Auburn Gen. Hosp.*, 10 Wash. App. 361, 517 P.2d 240 (1973); and *Rao v. Board of County Comm'rs.*, 80 Wash. 2d 695, 497 P.2d 591 (1972), *cert. denied*, 409 U.S. 1017 (1972); and Dr. Maurice Silver: *Silver v. Queen's Hosp.*, 63 Hawaii 430, 629 P.2d 1116 (1981); *Silver v. Queen's Hosp.*, 518 F.2d 555 (9th Cir. 1975), *cert. denied*, 424 U.S. 968 (1976); *Silver v. Castle Memorial Hosp.*, 53 Hawaii 675, 501 P.2d 60 (1972); *Silver v. Castle Memorial Hosp.*, 53 Hawaii 475, 497 P.2d 564 (1972), *cert. denied*, 409 U.S. 1048 (1972), *reh. denied*, 409 U.S. 1131 (1973).

86. See, e.g., *Peterson v. Tucson Gen. Hosp., Inc.*, 114 Ariz. App. 66, 559 P.2d 186 (1976); *Anderson v. Board of Trustees of Caro Community Hosp.*, 10 Mich. App. 348, 159 N.W.2d 347 (1968).

87. 135 N.J. Super. 393, 343 A.2d 489 (1975).

tation schedule. Termination of employment of a thoracic surgeon by the Veterans Administration has been likewise upheld.⁸⁸

The case of *McElhinney v. William Booth Memorial Hospital*,⁸⁹ presents an apparent contrary view. The Kentucky Supreme Court held that the hospital's evidence did not meet the standard set in its own bylaws. In this case, the appointment and clinical privileges of Dr. McElhinney, a surgeon, were terminated on the basis of "gross unethical or moral misconduct," the language used in the medical staff bylaws. The evidence against him was catalogued by the court as follows:

We glean from the evidence that appellant probably incurred the wrath of the hospital administration when he insisted that an investigation be made of the complaint of one of his surgical patients that a supervisory nurse had made lesbian overtures to her. It seems that [h]e also complained about the dust levels in the operating room. He entered a collision course with a physician named Richfield, who was the chief of pathology at the hospital complain[ing] that Richfield was too frequently unavailable to read frozen section slides and left too much responsibility to assistants who were not pathologists. [He] was dissatisfied with the performance of the X-ray department. He entered criticisms of professional performance and hospital procedure upon the records. [He] was doubtless somewhat abrasive to others in his insistence upon what he conceived to be required standards of care.⁹⁰

In finding for the physician and directing that Dr. McElhinney be reinstated, the court determined that his conduct did not violate the *standards* for termination expressed in the bylaws.⁹¹

It is plain from the court's language that it perceived the hospital's action as an attempt, for essentially petty reasons, to jettison "an especially competent, dedicated and busy surgeon whose prime concern is the welfare of his patients and the improvement of hospital conditions."⁹² Because the pertinent bylaw provisions were quite broad and, more importantly, required that the offending

88. *Gilbert v. Johnson*, 419 F. Supp. 859 (N.D. Ga. 1976).

89. 544 S.W.2d 216 (Ky. 1976).

90. *Id.* at 217.

91. *Id.* at 218. The provision in question provided for suspension and termination substantially as follows: "Suspension: (1) gross professional incompetence or dereliction, (2) gross unethical or moral misconduct, (3) violations of hospital regulations and policies to such an extent that disciplinary action is deemed advisable. Termination: 'Violation of sufficient gravity to warrant such action.'" The court said: "The express standards, vague though they be, do not condemn criticisms relating to treatment of patients or hospital practice nor do they proscribe inability to get along with some doctors or hospital personnel." *Id.*

92. *Id.* at 217. See also *Rosner v. Eden Township Hosp. Dist.*, 58 Cal. 2d 592, 375 P.2d 431, 25 Cal. Rptr. 551 (1962).

conduct be *gross*, it is not surprising that the court found them to be a standard not met by the evidence and not sufficiently definite in proscribing the conduct on which the physician's termination was grounded.⁹³

It is essential to note that the court expressed "no opinion as to the validity of a reasonably definite standard undertaking to proscribe and make a cause of termination inability to work in harmony with other hospital personnel."⁹⁴ The court also observed that none of the charges against the doctor "affect patient care." Thus, the case cannot be read as a rejection of the hospital's right to terminate a staff appointment for disruptive behavior.

A particular concern respecting the question of termination during appointment is that a single episode of disruptive behavior which, taken alone, might not appear to be sufficiently serious to warrant revocation of privileges, may actually be the one in a series of similar episodes which render the practitioner's continued presence in the hospital no longer tolerable. The hospital need not wait until reappointment time to act, nor should it be reluctant to initiate proceedings because it did not deny reappointment on the basis of the previous episodes.

This is an issue which is often raised by practitioners when they are finally called to task. They urge that because the hospital did not act in a particular instance in the past, it is precluded by some form of *institutional laches* from considering past behavior when it eventually acts to discipline the disruptive practitioner. No court has yet held that by failing to take action at some particular point in a continuing course of disruptive conduct, the hospital has, in effect, waived earlier incidents and is therefore foreclosed from considering them in revoking an appointment.

In fact, the exact opposite view was maintained by the Colorado Court of Appeals in *Leonard v. Board of Directors, Prowers County Hospital District*,⁹⁵ when it rejected a physician's claim that the use of a 1977 complaint against him in a hearing held in 1980 "prove[d] the board's bias against him because since 1977 the board had annually renewed [his] staff privileges."⁹⁶ The court

93. 544 S.W.2d at 218. Dr. McElhinney subsequently filed an antitrust suit against numerous defendants which was ultimately decided in favor of the defendants. See *supra* note 23.

94. 544 S.W.2d at 218.

95. 673 P.2d 1019 (Colo. App. 1983).

96. *Id.* at 1023.

found that the doctor's " 'stale charge' argument"⁹⁷ was without merit.

Likewise, in *Miller v. Indiana Hospital*,⁹⁸ on a similar question, the Pennsylvania Superior Court stated:

Merely reappointing appellant annually to the staff did not indicate an intention on the part of the hospital to ignore the cumulative effect of appellant's prior misconduct. Appellant has neither alleged nor proven any reliance upon the assumption that the actions of the hospital constituted a waiver. It was therefore proper for the hospital committees to consider prior misconduct which may not have been so egregious in any one year as to warrant denial of reappointment, but the cumulative effect of which called for appellant's dismissal from the staff.⁹⁹

2. *Summary Suspension During the Term of Appointment*

An important related issue is whether the hospital medical staff leadership or management may invoke the remedy of summary suspension¹⁰⁰ in the case of either a single episode of disruptiveness or in light of a pattern of prior misconduct. There is authority for summary action when only one instance of clinical misbehavior comes to light.¹⁰¹ Perhaps the same rationale could apply to disruptive, as distinguished from clinical, misbehavior. The misconduct or disruptive behavior, however, would have to be of such severity and immediacy that it can be shown to threaten patient safety or directly impair the orderly operation and management of the institution. The courts are divided on this question. Some suggest that summary suspension is usually not the first choice of remedy for handling the disruptive practitioner.¹⁰²

A good example of a situation in which summary suspension was

97. *Id.*

98. 277 Pa. Super. 37, 419 A.2d 1191 (1980).

99. *Id.* at 377, 419 A.2d at 1194. See also *Rutledge v. St. Vincent Memorial Hosp.*, 67 Ill. App. 2d 156, 214 N.E.2d 131 (1966).

100. The vast majority of hospital medical staff bylaws contain provisions which permit designated medical staff leadership, the chief executive officer and the chairman of the hospital board to suspend practitioners summarily in situations involving threats to patient safety or the orderly operations of the hospital.

101. See, e.g., *Suckle v. Madison Gen. Hosp.*, 362 F. Supp. 1196, 1214 n.5 (W.D. Wis. 1973), *aff'd*, 499 F.2d 1364 (7th Cir. 1974); *Storrs v. Lutheran Hosps. and Homes Soc'y. of Am., Inc.*, 661 P.2d 632 (Alaska 1983); cf. *Citta v. Delaware Valley Hosp.*, 313 F. Supp. 301 (E.D. Pa. 1970).

102. See, e.g., *McMillan v. Anchorage Community Hosp.*, 646 P.2d 857 (Alaska 1982); *Park Hosp. Dist. v. District Court*, 192 Col. 69, 555 P.2d 984 (1976) (en banc); *Ritter v. Board of Comm'rs of Adams County Pub. Hosp. Dist. No. 1*, 96 Wash. 2d 503, 637 P.2d 940 (1981) (en banc); cf. *Eidelson v. Archer*, 645 P.2d 171, 180 (Alaska 1982).

disapproved is *McMillan v. Anchorage Community Hospital*.¹⁰³ In 1975, while Dr. McMillan, an anesthesiologist who had been appointed to the medical staff of the defendant hospital two years earlier, was out of state taking board certification examinations, the chief executive officer sent a letter to his home summarily suspending his privileges because of his disruptive behavior. According to the court, "[t]he charge of disruptiveness was based on a series of problems and incidents occurring from 1973 through 1975 between McMillan and the nursing staff, other staff physicians, a nurse anesthetist, and the relatives of several patients."¹⁰⁴ Dr. McMillan requested and was granted a hearing. The hearing committee upheld the suspension and the board affirmed the hearing committee's decision. Dr. McMillan sued.

The case eventually reached the Alaska Supreme Court. The issue was whether the circumstances leading to the charge of disruptiveness against McMillan were sufficient for summary suspension of his privileges. Dr. McMillan argued that under the terms of the medical staff bylaws and the requirements of due process, summary suspension is only proper where there is some emergency or immediate need for suspension in the best interests of patient care. Although the court found that "there need not always be evidence of a clear connection between disruptive conduct and any immediate threat to patient care in order to justify suspension of staff privileges on the basis of disruptive conduct,"¹⁰⁵ it concluded that in this case the summary suspension was not justified.¹⁰⁶

Despite this conclusion, however, the court declined to order the hospital to reinstate him as he had requested. Instead, the court ordered the hospital to compensate Dr. McMillan for his loss of income from the date of the summary suspension until the time that he was properly suspended following the hearing under the medical staff bylaws.

Clinical misbehavior together with patterns of disruption will support summary action. In *Kiracofe v. Reid Memorial Hospital*,¹⁰⁷ a physician was summarily suspended because of his clinical

103. 646 P.2d 857 (Alaska 1982).

104. *Id.* at 859.

105. *Id.* at 867 n.13.

106. *Id.* at 866. This conclusion was based in large part on the testimony of the hospital's chief executive officer, which demonstrated that the doctor was viewed as a continuing problem and it was a consensus to get rid of him so that things could be more pleasant. *Id.* at 860 n.3.

107. ___ Ind. App. ___, 461 N.E.2d 1134 (1984). See also *Cipriotti v. Board of Directors of Northridge Hosp. Found. Medical Center*, 147 Cal. App. 3d 144, 196 Cal. Rptr. 367 (1983).

judgment in treating a patient. His appointment was later terminated, based not only upon that incident, but also upon a history replete with disciplinary actions for disruptive behavior.

The particular incident in *Kiracofe* is instructive because it highlights the important role of the medical staff leadership in the disciplinary process. As the court noted, the chief of the medical staff summarily suspended Dr. Kiracofe for his treatment of a fourteen year old female patient, who was admitted into the hospital on January 21, 1982, with a diagnosis of pelvic inflammatory disease (PID). The admitting diagnosis was not substantiated by laboratory tests, nor did those tests reveal the presence of either disease or infection. (The probability of the existence of PID in a fourteen year old girl is extremely small.) Dr. Kiracofe ordered treatment with several antibiotics. The chief of family medicine questioned the advisability of continued hospitalization because the patient's charts indicated that the treatment was not working. He requested that Dr. Kiracofe consult another physician, which he initially refused to do.

On examination, the consulting physician concluded that the patient's problems were principally emotional, and he recommended discontinuance of antibiotics. Dr. Kiracofe continued to treat the patient for PID and prescribed an extremely strong antibiotic. This order was questioned and the chief of the medical staff met with Dr. Kiracofe and demanded that he relinquish treatment to another doctor. Kiracofe requested that the antibiotic be continued. Kiracofe was summarily suspended by the chief of staff that day pursuant to the bylaws. The chief of staff also filed formal charges against Kiracofe.

The medical staff executive committee met to review the suspension on March 9, 1982, and to hear evidence on Dr. Kiracofe's behalf. The committee reviewed his personal file which included a summary of past grievances against him. The committee upheld the summary suspension and voted to terminate Dr. Kiracofe's privileges. Kiracofe appealed the committee's recommendation to the ad hoc committee, which voted to uphold the suspension and recommended termination. Further appeal was made to an appellate review committee, which affirmed the termination. The actions of these committees were subsequently upheld by the board of directors.

In upholding the hospital's actions both in summarily sus-

pending Dr. Kiracofe and in relying on past patterns of inappropriate behavior, the Indiana Court of Appeals found that he had been treated fairly according to the hospital bylaws. The court reached this conclusion even though he was not accorded a hearing until after the summary suspension was imposed.¹⁰⁸

VI. SYNOPSIS: THE INABILITY TO WORK WITH OTHERS IS SUFFICIENT TO WARRANT EXCLUSION

It is apparent from the foregoing sections that disruptive behavior alone is sufficient to warrant a practitioner's exclusion from the hospital. It should also be apparent, however, that such a criterion by its very nature, cannot be explicitly defined for all cases. It may be difficult to apply in any particular situation. It raises serious questions: What is the line to be drawn between strong, but legitimate, questioning of hospital policy and divisiveness approaching disruption? Does the mere fact that one disagrees make one disagreeable? Despite these questions which go to the issue of application of the criterion, inability to work with others has been upheld by the courts as a sufficient reason for denying appointment or re-appointment and for terminating an appointment before the end of its term. Analysis of the cases suggests that the critical questions are whether the hospital applied the criterion reasonably and whether it afforded the aggrieved practitioner procedural due process. In short, the ability to get along with others as a criterion is a reasonable one, but it must be enforced fairly.

At one time, the question of the hospital's status as a public or private entity was of importance, but this question has diminished in significance. The due process requirement does not change because of the institution's legal status. A court will either apply the constitutional due process standard using the state action test¹⁰⁹ or

108. — Ind. App. at —, 461 N.E.2d at 1137-39. The majority held that Dr. Kiracofe was not entitled to due process under the 14th amendment to the Constitution because the hospital was not a public hospital nor was there proof of state action. *Id.* An interesting concurring opinion questioned the majority's position but agreed with the outcome in this case. *Id.* at —, 461 N.E. 2d at 1141-44 (Ratliff, J., concurring). See *infra* note 109 and accompanying text.

109. *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974), established a "nexus" test for cases in which "state action" is alleged. In order to determine whether a hospital's actions constitute "state action," a court must inquire "whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." *Id.* at 351. By so holding that a privately-owned utility's termination of service is not "state action," the Court in *Jackson* made it clear that state involvement without state responsibility cannot establish this nexus.

With the case of *Modaber v. Culpeper Memorial Hosp.*, 674 F.2d 1023 (4th Cir. 1982), the

it will review the hospital's actions to determine if it followed its own bylaws, rules and regulations.¹¹⁰ In either aspect, the hospital is required by law, regulations and accreditation standards to be fair.¹¹¹

The hospital has the right, indeed the duty, to ensure that those who are appointed to its medical staff meet certain standards of professional competence and personal conduct so long as those standards are reasonably related to the hospital's mission of providing quality medical care in an efficiently run hospital. Most courts express reluctance to substitute their judgment for that of the governing board.

*Huffaker v. Bailey*¹¹² is an example of this judicial reluctance. Dr. Huffaker applied to a private hospital for appointment and clinical privileges and was turned down because he failed to sufficiently document, "(1) his ability to work with others in order to assure that his patients would be given a high quality of medical care; and (2) his competence in relation to the privileges requested."¹¹³ He sought mandamus to compel the hospital board to

Fourth Circuit Court of Appeals fell in line with the other circuits by holding that receipt of Hill-Burton Funds *does not* make the recipient's every act "state action." For other circuits in accord with this decision, see *Musso v. Suriano*, 586 F.2d 59, 62-63 (7th Cir. 1978), *cert. denied*, 440 U.S. 971 (1979); *Hodge v. Paoli Memorial Hosp.*, 576 F.2d 563, 564 (3d Cir. 1978) (per curiam); *Schlein v. Milford Hosp., Inc.*, 561 F.2d 427, 429 (2d Cir. 1977) (per curiam); *Madry v. Sorel*, 558 F.2d 303, 305-06 (5th Cir. 1977), *cert. denied*, 434 U.S. 1086 (1978); *Greco v. Orange Memorial Hosp. Corp.*, 513 F.2d 873, 880-81 (5th Cir. 1975); *Briscoe v. Bock*, 540 F.2d 392, 395 (8th Cir. 1976); *Taylor v. St. Vincent's Hosp.*, 523 F.2d 75, 77 (9th Cir. 1975), *cert. denied*, 424 U.S. 948 (1976); *Watkins v. Mercy Medical Center*, 520 F.2d 894, 895-06 (9th Cir. 1975) (*quoting* *Ascherman v. Presbyterian Hosp. of Pac. Medical Center, Inc.*, 507 F.2d 1103, 1105 (9th Cir. 1974)). *See also* *Ward v. St. Anthony Hosp.*, 476 F.2d 671, 675 (10th Cir. 1973) (*pre-Jackson*).

110. *See, e.g.*, *Feldman v. St. Mary's Hosp. and Health Center*, 126 Ariz. 262, 614 P.2d 343 (1980); *Avol v. Hawthore Community Hosp.*, 135 Cal. App. 3d 101, 184 Cal. Rptr. 914 (1982); *Dance v. North Broward Hosp. Dist.*, 420 So. 2d 315 (Fla. 1982); *Silver v. Castle Memorial Hosp.*, 53 Hawaii 475, 497 P.2d 564, *cert. denied*, 409 U.S. 1048 (1972), *reh. denied*, 409 U.S. 1131 (1973); *McElhinney v. William Booth Memorial Hosp.*, 544 S.W.2d 216 (Ky. 1976); *Bricker v. Sceva Speare Memorial Hosp.*, 111 N.H. 276, 281 A.2d 589 (1971), *cert. denied*, 404 U.S. 995 (1971); *Greisman v. Newcomb Hosp.*, 40 N.J. 389, 192 A.2d 817 (1963); *Cameron v. New Hanover Memorial Hosp., Inc.*, 58 N.C. App. 414, 293 S.E.2d 901 (1982); *Gotsis v. Lorain Community Hosp.*, 46 Ohio App. 2d 8, 345 N.E.2d 641 (1974); *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398 (1975); *Woodard v. Porter Hosp., Inc.*, 125 Vt. 419, 217 A.2d 37 (1966). *See also supra* note 33.

111. *See infra* notes 128 & 129 and accompanying text.

112. 273 Or. 273, 540 P.2d 1398 (1975).

113. *Id.* at 275, 540 P.2d at 1399. The pertinent bylaw provided:

Only physicians and dentists licensed to practice in the State of Oregon, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their *ability to work with others*, with sufficient adequacy to assure the medical staff and the gov-

grant the requested privileges. The Oregon Supreme Court upheld the lower court's sustaining of the hospital's demurrer, despite the petitioner's argument that the language of the bylaws was impermissibly vague. The court disagreed, saying:

Once it is accepted that a hospital may set higher standards of care for hospital staff admissions than the mere possession of a state license it becomes difficult to conceive of ways of setting out in greater detail the higher degree of medical care desired. Fruitless elaborations may be indulged in without further specificity. Rather than curtailing the discretion at the outset for failure to define that which would be difficult to define in any event, the court should more appropriately look to the exercise of the discretion to see if it has been abused.¹¹⁴

Regarding Dr. Huffaker's specific objection that the criterion of documented ability to work well with others was not a valid consideration because it had no bearing on his medical competence and was not related to the quality of patient care, the court responded:

This contention has some merit, and raises a rather sensitive issue. The issue of a pleasant and cooperative personality has no direct influence on medical competence in a technical sense. But it must be remembered that the hospital is concerned not only with medical competence, but primarily with the *quality of care* the patients receive in the hospital.

Most other courts have found that the factor of ability to work smoothly with others is reasonably related to the hospital's object of ensuring patient welfare. This conclusion seems justified for, in the modern hospital, staff members are frequently required to work together or in teams, and a member who, because of personality or otherwise, is incapable of getting along, could severely hinder the effective treatment of patients.¹¹⁵

A strong line of cases from other jurisdictions supports this view.¹¹⁶ Several cases from California are clearly in opposition.¹¹⁷ As

erning body that any patient treated by them in the hospital will be given a *high quality of medical care*, shall be qualified for membership on the medical staff
Id. at 276, 540 P.2d at 1399 (emphasis added by the court).

114. *Id.* at 276-77, 540 P.2d at 1399-400.

115. *Id.* at 277-78, 540 P.2d at 1400 (emphasis in original).

116. *See, e.g.,* Shulman v. Washington Hosp. Center, 222 F. Supp. 59, 64 (D.D.C. 1963); Silver v. Castle Memorial Hosp., 53 Hawaii 475, 478-79, 497 P.2d 564, 568, *cert. denied*, 409 U.S. 1048 (1972), *reh. denied*, 409 U.S. 1131 (1973); Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 280-81, 281 A.2d 589, 593, *cert. denied*, 404 U.S. 995 (1971); Sussman v. Overlook Hosp. Ass'n, 95 N.J. Super. 418, 422-23, 231 A.2d 389, 393 (1967); Hagan v. Osteopathic Gen. Hosp. of Rhode Island, 102 R.I. 717, 726, 232 A.2d 596, 601 (1967). *See also supra* note 17.

117. *See* Wyatt v. Tahoe Forest Hosp. Dist., 174 Cal. App. 2d 709, 345 P.2d 93 (1959); Rosner v. Eden Township Hosp. Dist., 58 Cal. 2d 592, 375 P.2d 431, 25 Cal. Rptr. 551 (1962); Martino v. Concord Community Hosp. Dist., 233 Cal. App. 2d 51, 43 Cal. Rptr. 255

noted previously in *Miller v. Eisenhower Medical Center*,¹¹⁸ the California Supreme Court said that the hospital's appointment criterion of "ability to work with others" was to be "read to demand that there be a demonstrable nexus between the applicant's ability to 'work with' others and the effect of that ability on the quality of patient care provided."¹¹⁹ In reaching its decision, the court noted that all hospital institutions are primarily concerned with the provision of high quality care, that medical staff decisions must take into account all factors which relate to the goal of high quality care, and that the ability to get along with others is such a factor.¹²⁰ The court held, however, that in order to avoid the dangers of arbitrary or irrational application or use as a subterfuge to hide inappropriate considerations, the criterion must be interpreted

to demand a showing, in cases of rejection on this ground, that an applicant's inability to "work with others" in the hospital setting is such as to present a *real and substantial danger* that patients treated by him might receive other than a "high quality of medical care" at the facility if he were admitted to membership.¹²¹

After *Miller*, the California appellate court in *Pick v. Santa Ana-Tustin Community Hospital*¹²² did uphold a hospital ad hoc committee's finding that "Dr. Pick's manifested personality would create and present a real and substantial danger to the high quality of medical care both to his patients as well as other physicians' patients."¹²³

The California cases aside, there is a strong consensus among other jurisdictions that the ability to work with others alone is an appropriate criterion to apply with respect to applicants for admis-

(1965). *But see* Comment, *Hospital Staff Privileges: The Need for Legislation*, 17 STAN. L. REV. 900 (1965), which is critical of such holdings. For example, "[I]t is difficult to understand how a hospital is to adhere to modern concepts of hospital administration if it cannot consider the ability of its staff members to cooperate . . ." *Id.* at 916.

118. 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980); *see also supra* notes 61-68 and accompanying text.

119. *Id.* at 628, 614 P.2d at 266, 166 Cal. Rptr. at 834.

120. *Id.* at 628, 614 P.2d at 267, 166 Cal. Rptr. at 835.

121. *Id.* at 629, 614 P.2d at 267, 166 Cal. Rptr. at 835.

122. 130 Cal. App. 3d 970, 182 Cal. Rptr. 85 (1982); *see supra* notes 54-58 and accompanying text.

123. *Id.* at 975 n.4, 182 Cal. Rptr. at 88 n.4. It seems obvious that the medical staff committee was ably advised as to the meaning of *Miller v. Eisenhower Medical Center*. *See also* Unterthiner v. Desert Hosp. Dist. of Palm Springs, 33 Cal. 3d 285, 188 Cal. Rptr. 590, 656 P.2d 554 (1982); Cipriotti v. Board of Directors of Northridge Hosp. Found. Medical Center, 147 Cal. App. 3d 144, 196 Cal. Rptr. 367 (1983).

sion.¹²⁴ The proof required in all other jurisdictions to support a denial is less rigorous than California's "real and substantial danger" test articulated in *Miller* and applied in *Pick*. Indeed, several courts seem to require merely that the hospital show the possibility of prospective disharmony.¹²⁵

While it is clear that inability to work with others is an acceptable ground for denial of initial appointment, refusal to reappoint, or termination during appointment, fundamental principles of due process play a vital role in the way courts will view the action which hospital management takes in any particular situation.

VII. DUE PROCESS CONSIDERATIONS

The courts will increasingly be called upon to balance the sharply conflicting, but equally compelling, interests of practitioners and the hospital. While there is no right to medical staff appointment,¹²⁶ its attainment is vital to most physicians and other health care practitioners. Continuing technological advances in medical science, complicated and sophisticated techniques for diagnosis and treatment, and the availability of an army of highly skilled health care professionals other than physicians who form part of the institutional team, make hospital appointment a necessity. At the same time, hospitals are required to be much more selective about medical staff appointments because of corporate liability.¹²⁷ In this scenario, the disruptive practitioner creates due process dilemmas for the hospital.

Aggrieved practitioners are entitled to due process whether they are denied initial appointment, terminated during the appointment period or not reappointed.¹²⁸ Both aspects of due process—procedural and substantive—must be considered when the hospital has to deal with the disruptive practitioner.

The essential elements of procedural due process are well-established. The aggrieved practitioner who requests a hearing must re-

124. See *supra* note 59.

125. See, e.g., *Hagen v. Osteopathic Gen. Hosp. of Rhode Island*, 201 R.I. 717, 232 A.2d 596 (1967), discussed *supra* notes 70-71; *Huffaker v. Bailey*, 273 Or. 273, 540 P.2d 1398 (1975), discussed *supra* notes 112-15 and accompanying text.

126. See *supra* note 33.

127. See *supra* notes 6 & 7.

128. This subject is well covered in the literature; see, e.g., Ludlam, *Physician-Hospital Relations: The Role of Staff Privileges*, 35 LAW AND CONTEMP. PROBS. 879-900 (1970); Springer, *Medical Staff Law and the Hospital*, 285 NEW ENGLAND JOURNAL OF MEDICINE 952-59 (Oct. 21 1971); Cray, *Due Process Considerations in Hospital Staff Privilege Cases*, 7 HASTINGS CONST. L. Q. 217 (Fall 1979).

ceive notice of the grounds for the proposed adverse action to be taken against him and notice of the hearing date, time and place. The hearing should be before an impartial tribunal, that is, one whose members have not previously officially acted on matters relating to the requested hearing. The aggrieved practitioner must have an opportunity to produce evidence in his behalf and to rebut the evidence against him. The findings and recommendations of the hearing tribunal must be based on evidence produced at the hearing. Finally, the aggrieved practitioner must have an opportunity to appeal to a higher authority—generally the governing body of the institution.¹²⁹

Substantive due process encompasses notions of fairness with respect to rules, standards, criteria and measures to be applied to practitioners. Thus, the rules and standards must be reasonable and not discriminatory; they must not be arbitrary or capricious, and they must be fairly applied.¹³⁰

With respect to substantive due process, ability to work with others and similar personal qualities are valid criteria for hospitals to apply in deciding to appoint or reappoint practitioners. In *Schlein v. Milford Hospital*,¹³¹ the court noted:

[I]t is entirely consistent with due process for a hospital, in deciding whether to grant staff privileges, to evaluate those personal qualities of a physician that reasonably relate to his ability to function effectively within a hospital environment. A doctor's ability to work well with others, for instance, is a factor that could significantly influence the standard of care his patients received. Due process does not limit the hospital's consideration to technical medical skills.¹³²

All courts agree that the personal qualities noted above are applicable to situations in which patient care and safety are threatened. It is our belief that such criteria are equally relevant to the practitioner whose inability to work with others disrupts or adversely affects the orderly operation and management of the institution. If the hospital is prevented from operating efficiently and effectively, sooner or later patient care will suffer. Thus, hospital

129. See *Ascherman v. San Francisco Medical Soc'ys*, 39 Cal. App. 3d 623, 114 Cal. Rptr. 681 (1974); *Silver*, 629 P.2d 1116; *Ladenheim*, 394 N.E.2d 770. The JCAH, *supra* note 3, at 10.2.4.2 and 10.4.2.10 requires a "fair hearing," but does not specifically state the elements necessary to transform a hearing into a fair one. Equally ambiguous language is contained in the Medicare Conditions of Participation, 42 C.F.R. § 405.1021(e)(7) (1983).

130. Substantive due process in the hospital setting is concerned with the fairness of such things as hospital and medical staff bylaw provisions, rules and regulations.

131. 423 F. Supp. 541 (D. Conn. 1976).

132. *Id.* at 544. See *supra* notes 53-76 and accompanying text.

management must have wide latitude to define in broad terms the type of behavior which is deemed detrimental either to high quality care or to the orderly efficient operation of the institution. Moreover, the hospital must have the capability to address the problem with a variety of strategies ranging from collegially informal approaches to strict due process procedures.

VIII. THE HOSPITAL'S RANGE OF RESPONSES TO DISRUPTIVE BEHAVIOR SHORT OF FORMAL DUE PROCESS PROCEDURES

In order to handle the disruptive practitioner effectively, hospital management, particularly the medical staff leadership, must have a range of options for actions which will not trigger the formal procedural due process mechanisms. It is difficult enough for hospitals to handle the clinically incompetent or marginally competent practitioner, that is, to develop sufficient evidence to support the grounds for appropriate corrective action. It is even more difficult and time consuming to develop the supporting justification for the formal due process proceeding against the disruptive practitioner. As we have noted, the practitioner may be a competent clinician, perhaps even among the best in the institution. Many of his colleagues may never experience his unacceptable behavior so that it is more likely that they will believe his argument that the others are "out to get him." Moreover, support personnel, who know about his behavior, may be intimidated by the abusive individual. Their complaints are often ignored or discounted by the leadership.¹³³ They will not report him or testify against him because they fear reprisal. Indeed, even the peers of the disruptive practitioner are often threatened and intimidated by threats of reprisal or litigation. Disruptive practitioners are much more likely to make personal attacks on the medical staff leadership and hospital management. The longer they are permitted to get away with the offensive behavior the more difficult it will be to stop them.

Hospital medical staff bylaws should provide for administrative actions which may be undertaken by medical staff leadership or hospital management without resort to formal procedural due pro-

133. In a California hospital some time ago, operating room personnel continually reported instances of gross sexual abuse of anesthetized female patients by an anesthesiologist. The reports were ignored for at least a year. Finally, an anonymous letter to law enforcement officials triggered a massive newspaper expose, state investigations, conviction of the physician, hundreds of lawsuits, and of course, almost complete disruption of the hospital. See Horty, *What Did They Know? When Did They Know It?*, ACTION-KIT FOR HOSPITAL LAW (Sept. 1979).

cess requirements. Such administrative actions include interviews, written admonitions, letters of reprimand, probation, supervision and suspension of admitting privileges for a specific time period.¹³⁴ These administrative actions are advantageous, in that they give the practitioner early notice that his behavior is taken seriously and will not be tolerated by the leadership. They also provide other practitioners and hospital employees with a mechanism by which they can trigger action by those authorized to act.

An administrative reprimand will serve notice that the practitioner's behavior is creating inharmonious working conditions which may result in impaired patient care. Such an early intervention also affords the affected physician an opportunity to either discuss his concerns and explain his actions or moderate his behavior. Moreover, if there is no justification for the physician's action, hospital management will be empowered to act quickly and effectively.

The hospital's medical staff and corporate bylaws must provide a method by which admonitions, letters of reprimand, probation and even suspension of admitting privileges for a period of up to thirty days may be used by the hospital as warnings to a disruptive practitioner. Both the medical staff and the corporate bylaws must also expressly provide that the due process provisions, which are an integral part of a formal disciplinary proceeding, do not apply to these administrative actions.¹³⁵ The informal action permits the hospital to attempt to alter behavior which the hospital has found to be intolerable.

These strategies are designed to provide a mechanism for early resolution of potentially divisive situations. It is acknowledged that an administrative suspension will affect the physician's ability to admit and treat patients within the hospital. Therefore, it is likely that such action will have a negative financial impact on the physician. However, the hospital's general corporate authority includes the ability to temporarily suspend an individual if such action is necessary in order to provide a safe environment for hospital pa-

134. It is noted that certain states have enacted statutes requiring that the curtailment of clinical privileges due to misconduct or professional malpractice be reported to the state board of medicine or osteopathy. *See, e.g.*, Reporting Incidents of Professional Misconduct Act, Act No. 1985-48, 1985 PA. LEGIS. SERV. 269 (to be codified at 35 PA. CONS. STAT. ANN. § 448.806.1). Such a statute does not affect whether the hospital can legally suspend a physician's admitting privileges without resorting to the due process provisions of the medical staff bylaws. However, such action will most likely have to be reported to the appropriate state board.

135. *See id.*

tients. If the suspension is for a period of less than thirty days, the medical staff leadership or the hospital should be free to act without fear of injunction or the strict and time-consuming requirements of a formal hearing before effective action can be taken. Here, one must balance the broad interests of the hospital to maintain a harmonious and safe environment for all its patients, employees and medical staff against the interests of one practitioner whose actions are deemed to be disruptive. In this context, the hospital's interests should prevail even against an assertion of constitutionally protected free speech.¹³⁶

Informal and rapid administrative action will also enhance institutional morale—an important concern of hospitals in this time of increasing risks. As noted earlier, hospital employees or other medical staff appointees are often the primary targets of the disruptive practitioner. If these “victims” view medical staff leadership or hospital administration as indecisive and impotent, they may leave the hospital. No hospital can afford to lose its experienced employees, who are especially unlikely to tolerate unwarranted abuse. If disgusted medical staff practitioners decide to take their patients to other more harmonious and collegial health care settings, the hospital will suffer immediate financial consequences.

It is also possible that aggrieved employees may take matters into their own hands.¹³⁷ In *Thompson v. Grays Harbor Community Hospital*,¹³⁸ a hospital was faced with a practitioner whose inappropriate behavior included reference to another staff appointee as a “butcher,” disruptive behavior toward hospital employees, and temper tantrums. Rather than take quick administrative action, the hospital's approach was described by the trial court as “careful

136. See, e.g., *Herrington v. Mississippi Regional Medical Center*, 512 F. Supp. 1317 (S.D. Miss. 1981), where a public hospital was held to have acted properly in discharging an anesthetist whose criticisms undermined the working relationship between a superior and herself, which was deemed essential to efficient and safe departmental relations. The court concluded:

In summary, the Court finds, as did the jury, that the plaintiff's criticisms were not protected under the First Amendment. In any event, the defendants proved that the plaintiff would have been fired even in the absence of the alleged protected speech. Applying the ultimate balance to the issues of fact and law in the case, the Court concludes that the ultimate balance weighs heavily in favor of the hospital's interest in providing anesthesia services to the public unencumbered by internal strife and discord.

Id. at 1321. See also *Hoberman v. Lock Haven Hosp.*, 377 F. Supp. 1178 (M.D. Pa. 1974).

137. See *supra* note 133.

138. 36 Wash. App. 300, 675 P.2d 239 (1983).

and restrained."¹³⁹ Faced with a hospital administration which refused to react to their complaints, the hospital's nurses retaliated by trying to harm Dr. Thompson economically in the following manner:

Various parents testified they took their children to the emergency room at Grays Harbor Community Hospital and asked for Dr. Thompson. According to the witnesses the hospital staff made them wait longer, told them falsely Dr. Thompson was not available and made some disparaging remarks about her. In some cases, the parents were encouraged to have their children treated by the house physician instead of by Dr. Thompson. Some of the parents followed this advice.¹⁴⁰

Such testimony led to a verdict for Dr. Thompson, which was based on the jury's finding that as a result of the action of its employees, the hospital was vicariously liable for the tortious interference with Dr. Thompson's medical practice. The trial judge, however, felt the verdict was unjustified and entered a judgment not withstanding the verdict. The court of appeals disagreed with the trial court and reversed the judgment, thus reinstating the jury's verdict and \$90,000 in damages on behalf of Dr. Thompson.

The *Thompson* case clearly represents a Hobson's choice for the hospital. Delay can often lead to liability. At the same time, immediate action by the hospital may lead to litigation by the disruptive physician.

In our view, the hospital should lean toward taking action in the interests of patient care and a well-run hospital. The risks of delay far outweigh the risks of an early attempt to deter disruptive behavior.

IX. CONCLUSION

Handling the disruptive practitioner is a growing problem for hospital medical staff and administrative leadership. The dilemma of the modern hospital is that its traditions do not provide that leadership with the proper background to deal effectively with disruptive behavior, but legal and other external pressures compel a rapid learning process. Not only is disruptive behavior infinitely variable, but it is likely to increase as those pressures continue to mount on institutions and practitioners. Hospitals must be able to employ a wide variety of options to deal with this complicated and multifaceted problem, while at the same time providing appropri-

139. *Id.* at 311 n.5, 675 P.2d at 245 n.5.

140. *Id.* at 303, 675 P.2d at 241.

ate deference to fundamental due process considerations. The ultimate goal of the hospital—its legal mandate—is consistent high quality patient care. Today, that goal will be realized in institutions which maintain harmonious environments with strong, intelligent and effective lay and medical staff leadership under sound, flexible bylaws. All of hospital management—the governing boards, the medical staff leaders and the administration—will be called upon to make difficult decisions involving the equally compelling, but often directly conflicting, interests of the hospital and the practitioner. The balance today must be in favor of the institutional imperative.

