Health Care Compliance Association

Quality of Care Compliance Conference

DISRUPTIVE PRACTITIONERS AND THE 2009 JOINT COMMISSION STANDARDS

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OVERVIEW

Disruptive physician behaviors have long been tolerated in part due to administrators worrying about antagonizing a physician who brings patients and revenue into the organization. Also, physicians were reluctant to counsel their peers particularly around issues related to behavioral compliance. While poor behavior has been tolerated in the past, these behaviors by physicians or other health care staff must be curtailed according to new JCAHO standards effective January 1, 2009. The new standard was developed for

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all JCAHO accredited providers, including hospitals, nursing homes, ambulatory surgery centers and home health agencies.

Based on studies on the subject,[1] JCAHO views disruptive behavior as a serious threat to patient safety and the overall quality of care. This new standard requires accredited health care organizations to create a code of conduct that defines acceptable and unacceptable behaviors and to establish a formal process for managing unacceptable behavior. This will require health care organizations to define disruptive behaviors and implement a process for managing them. Not only that, these standards will also impact medical staff bylaws, employment policies, executive committee functions, departmental leadership, peer review, and the credentialing and performance improvement processes. (It is noteworthy that the American Medical Association requested JCAHO to delay implementation of this new standard;[2] however, JCAHO did not accede.)

NEW JCAHO LD.03.01.01

"Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01)[] that addresses disruptive and inappropriate behaviors in two of its elements of performance:

> EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
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> EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors. In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism."

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[1] *See* Lucian L. Leape, M.D., & John A. Fromson, M.D., *Problem Doctors: Is there a System-Level Solution?*, ANNALS OF INTERNAL MED., Jan. 17, 2006, Vol. 144, No. 2, at 107-115; *see also* Alan A. Rosenstein, M.D., M.B.A. & Michelle O'Daniel, M.H.A., M.S.G., *A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety*, THE JOINT COMM'N J. ON QUALITY & PATIENT SAFETY, Aug. 2008, Vol. 34, No. 8, at 464-471.

[2] Kevin B. O'Reilly, AMA meeting: Disruptive behavior standard draws fire, Am. Med. News, Dec. 1, 2008, http://www.ama-assn.org/amednews/2008/12/01/prse1201.htm.

This new standard, set forth by JCAHO as a Sentinel Event Alert, may be found at http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm. *Behaviors that undermine a culture of safety*, Sentinel Event Alert, Joint Commission, No. 40, Jul. 9, 2008.

OTHER SUGGESTED ACTIONS BY JCAHO REGARDING JCAHO LD.03.01.01
(Comments from speakers are in italics.)

"**1. Educate all team members both physicians and non-physician staff on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.**" *This requirement seems reasonable. However, unless training is a required part of medical staff membership, it will be very difficult to assemble the medical staff for this type of training -- much easier to compel this type of training with regard to employees.*

"**2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.**" *This action will present challenges with regard to non-employed physicians, in particular. It will be difficult to have equitable treatment among all staff when physicians are generally disciplined by their peers. If this suggested action is implemented, it may require that medical staff bylaws be amended to contain similar provisions with regard to enforcement and accountability as are in personnel policies.*

"**3. Develop and implement policies and procedures/processes appropriate for the organization that address:**"

> "•**'Zero tolerance' for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.**" *This concept will require a significant commitment on the part of the medical staff and will clearly turn on the definitions, which are arrived at in discussions between medical staff and hospital administration.*
>
> "•**Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.**"

"•**Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior. Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.**" *Although non-retaliation clauses are beneficial for reducing the fear of intimidation or retribution against the person reporting "disruptive behavior", organizations may wish to consider adding a requirement that reporting "disruptive behavior" includes a certification that the report is made in good faith and without malicious intent. Some may argue that having such a certification requirement may effectively cancel the non-retaliation clause; however, a "good faith and without malicious intent" standard would better protect the complaint system against frivolous and malicious reports. (For example, Virginia law requires certain healthcare providers to report certain disciplinary actions and impairments, and provides limited civil immunity to those submitting such reports. VA. CODE ANN. '' 54.1-2400.6 to 54.1-2400.8. However, such immunity is not available where "such person [submitting the report] acted in bad faith or with malicious intent." Id. at '' 54.1-2400.8.)*

"•**Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.**" *If an apology is to be given, it should include only expressions of benevolence, sorrow or sympathy, and nothing that could be reasonably construed as an admission of guilt or wrongdoing. Organizations should be careful in wording apologies and should consult legal counsel before making them. Many states (e.g., Arizona, California, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, and others) have laws providing some form of protection to such certain types of apologies, often as an evidentiary privilege in subsequent judicial or administrative proceedings. See Attachment D (State Apology Laws) - Virginia Joint Commission on Health Care and The Virginia Bar Association Report of the HJR 101 Study Committee (October 2008).*

"•**How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).**" *Decisions on the process for instituting disciplinary actions will obviously vary between individuals who are employees of a healthcare facility and individuals who are on the medical staff, but in private practice. Some healthcare facilities may have a progressive discipline policy already in place or may have a grievance policy in place which would need to be supplemented with regard to disruptive behaviors. Issues concerning loss of clinical privileges would need to be addressed in medical staff bylaws and the process for such disciplinary action would be as set forth in such bylaws. Although in some cases, healthcare facilities and or medical staffs may have discretion as to when to*

report to professional license bodies, other states may require such reports in the event of unprofessional conduct. See VA. CODE '54.1-2909 A(4).

"**4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.**" *Solicitation of input from the medical staff or nursing staff on this topic may be more easily achieved through separate meetings with nursing and medicine or through a formal/informal poll of these individuals. If these staffs are brought together to discuss the subject, there may be some reluctance to be as open in such a setting.*

"**5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution. Cultural assessment tools can also be used to measure whether or not attitudes change over time.**"

"**6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.**" *If an assessment tool is used, such as a survey of staff ,it is important that the assessment tool be cleared by individuals representing the medical staff and the nursing staff to ensure that questions are properly formatted and do not unfairly elicit negative responses toward one body or the other.*

"**7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services and patient advocates, both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods. Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.**"

"**8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal 'cup of coffee' conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. These interventions should initially be nonadversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety. Make use of mediators and conflict coaches when professional dispute resolution skills are needed.**" *Although informal 'cup of coffee' conversations may be a cost-effective way of addressing disruptive behavior, organizations should be cautious and mindful of any applicable state laws that provide limited civil immunity protection for peer review activities and protect the*

confidentiality of such activities. Certain laws, for example, may protect peer review activities that have been "officially" initiated. (For reference, attached are excerpts of certain peer review protection provided in the District of Columbia, Pennsylvania, Virginia and North Carolina.) Moreover, if any of the statements in those informal conversations may be used against the allegedly "disruptive" person in a "professional review action" (as defined in the Health Care Quality Improvement Act of 1986, as amended, 42 U.S.C. ' ' 11101 et seq.), organizations should evaluate whether appropriate due process protections are in place. See 42 U.S.C. ' 11112.

"**9. Conduct all interventions within the context of an organizational commitment to the health and wellbeing of all staff, with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.**" *The Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. ' 12101 et seq., may become implicated if these "pathologies" rise to the definition of a "disability" (see ADA ' 902). (N.B., the ADA was recently amended by the Americans with Disabilities Act Amendments Act of 2008, whereby the Equal Employment Opportunity Commission was charged, among other tasks, with revising the definition of a "disability".) If the ADA is applicable, or potentially applicable, to a particular episode or series of "disruptive behaviors", an organization's ability to discipline or to otherwise address these behaviors may be limited. However, in an effort to minimize these potential limitations, a hospital or medical staff may wish to consider whether its policies, bylaws or other organizational documents should include and/or have included a clear description of the "essential job functions" (or its analog). In other words, if a disabled physician cannot meet the essential job functions of a position, then he or she may not be afforded certain ADA protections.*

Consider the following example: Enraged by the hospital's nursing shortage and after waiting two hours for lab tests, Dr. Loudmouth takes out his frustration on the triage nurse by yelling profanities at her in a crowded hospital waiting room and by throwing magazines everywhere. A few days later, Dr. Loudmouth finds himself being investigated for violating the medical staff bylaw prohibition against disruptive behavior. Dr. Loudmouth defends such charges that he has some "mental health pathologies", for which he is actively seeking professional counseling and treatment, and that he is covered by the ADA. Although not dispositive of whether the ADA is applicable, the medical staff responds that even assuming that the ADA is applicable, the medical staff bylaws include a provision that "effective face-to-face and non-disruptive communication with medical staff members and hospital support staff" is an essential job function of all medical staff members.

"**10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.**"

"**11. Document all attempts to address intimidating and disruptive behaviors.**" *(See comments to Item 8 above.)*

SAMPLE DEFINITIONS OF "DISRUPTIVE BEHAVIOR"

Sample language from a hospital perspective (broad language):

- Sample No. 1: "***Disruptive and Inappropriate Behavior***: Disruptive and inappropriate behavior is interaction among hospital personnel, patients, family members or others that interferes or may interfere with patient care or hospital operations. Such behavior includes, but is not limited to, verbal abuse, loud or obscene comments, offensive comments based upon an individual=s gender, race, ethnicity, religion, disability or sexual orientation, misuse of operating room instruments or equipment, or inappropriate or unprofessional physical contact or gestures."

- Sample No. 2: "***Policy:*** All reported incidents of physician/staff disruptive behavior will be referred to the Medical Staff for either information or action.

Criteria: In an attempt to define physician/staff disruptive behavior, the following are offered as criteria in determining appropriate incidents to be reported:

A. Verbal or physical attacks leveled at other appointees to the hospital which are personal and irrelevant, or go beyond the bounds of professional conduct;

B. Non-constructive criticism addressed to the recipient in such a way as to intimidate, undermine confidence, belittle or imply stupidity, bad motives, or impugn the competency of the individual;

C. Impertinent and inappropriate written comments in the medical record impugning the quality of care of the hospital, or attacking particular physicians, hospital staff or hospital policy;

D. Imposing unnecessary demands on hospital staff which have nothing to do with better patient care, but serve only to burden the hospital staff with special techniques and procedures;

E. Rude or abusive conduct to other care givers;

F. Intentional abuse of hospital property and equipment;

G. Rude or abusive behavior to patients or visitors;

H. Derogatory comments about physicians, hospital staff, or treatment

being given the patient, or about the operation of the hospital; and/or

I. Threats and/or physical assaults on physicians, hospital staff, or any others in the hospital."

Sample language from the American Medical Association (*see* AMA Ethics Policy E-9.045(1)): "Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior."

AMERICAN MEDICAL ASSOCIATION - ETHICS POLICY

"E-9.045 Physicians with Disruptive Behavior
This Opinion is limited to the conduct of individual physicians and does not refer to physicians acting as a collective, which is considered separately in Opinion 9.025, "Collective Action and Patient Advocacy."

(1) Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one=s ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.

(2) Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician=s behavior is identified as disruptive. The medical staff bylaw provisions of policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness -- or equivalent committee.

(3) In developing policies that address physicians with disruptive behavior, attention should be paid to the following elements:

(a) Clearly stating principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment.

(b) Describing the behavior or types of behavior that will prompt intervention.

(c) Providing a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help identify a pattern that requires intervention.

(d) Establishing a process to review or verify reports of disruptive behavior.

(e) Establishing a process to notify a physician whose behavior is disruptive that a report has been made, and providing the physician with an opportunity to respond to the report.

(f) Including means of monitoring whether a physician=s disruptive conduct improves after intervention.

(g) Providing for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues," apply in particular cases.

(h) Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.

(i) Providing clear guidelines for the protection of confidentiality.

(j) Insuring that individuals who report physicians with disruptive behavior are duly protected. (I, II, VIII) Issued December 2000 based on the report "Physicians With Disruptive Behavior," adopted June 2000.

Last updated: Jul 23, 2002"

HOSPITAL'S PERSPECTIVE ON NEW JOINT COMMISSION STANDARDS

Disruptive Physician Behavior- Hospital Issues

- Hospital Personnel Manuals
  - " Disruptive behavior creates a hostile work environment - needs to be examined in light of existing employment manual
  - " EEOC Monitor can be point person
  - " Hospitals must establish a team approach among all staff at all levels
  - " Consider "whistle blower" protection as part of surveillance system (non-retaliation clauses) for "good faith" reporting

- Medical Staff Bylaws
  - " Disruptive and inappropriate behaviors should be grounds for discipline
  - " Require certain amount of education hours on this topic to be re-credentialed
  - " Incorporate a zero tolerance policy into bylaws
  - " Include non-retaliation clause - physicians should not retaliate against hospital personnel who report them in good faith

- Medical Staff Credentialing
  - " Interpersonal and communication skills and professionalism should be included in the standards to receive hospital privileges

- Code of Conduct
  - " Hospitals need to have a code of conduct that defines acceptable, disruptive and inappropriate behaviors

- Risk Management/ Quality Assurance
  - " Hospital must regularly evaluate the culture of safety and quality using valid and reliable tools
  - " Provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives
  - " Provide education that focuses on safety and quality for all individuals
  - " Make literature and advisories relevant to patient safety available to all individuals who work in the hospital
  - " Develop processes and policies regarding patient complaints of unprofessional or disruptive behavior

- *Reports to Board of Medicine may be impacted by new guidelines.

CONSIDERATIONS FOR HOSPITAL COUNSEL

- Review applicable state laws regarding peer review immunity and confidentiality protections to ensure that revisions to the Medical Staff Bylaws would not inadvertently fall outside of such protections.

- If applicable, review the terms of employment and service contracts to determine whether the definitions of unacceptable, disruptive and inappropriate behaviors could conflict with the Medical Staff bylaw revisions.

- Consider mediation services as method to resolve issues among Medical Staff members.

Scenario 1 - "Dr. Studly" and Dr. Uptight in the Operating Room

Dr. Stuart DaLeigh is a renowned neurosurgeon, who has developed a series of patented medical equipment and devices which he and only a handful of other neurosurgeons are qualified to operate and to implant. General St. Hospital, where Dr. DaLeigh now serves as chief of the medical staff, has invested almost $500,000 and other resources in Dr. DaLeigh and his clinical research. The hospital's investment is beginning to pay dividends. Since Dr. DaLeigh's addition to the medical staff and the public announcements of his patent awards and other medical breakthroughs, the hospital's patient census has had double digit annual increases, research grants are numerous and easily attainable, and highly desired medical subspecialists are now applying by the handfuls for employment positions and for medical staff privileges.

Not only is Dr. DaLeigh a successful and cutting edge neurosurgeon, he is charismatic and strikingly handsome. In fact, most of the females of the Medical Staff and of the nursing staff have nicknamed him "Dr. Studly" and address him by his nickname whenever patients are not present. At General St. Hospital, the operating room culture is one of sexual jokes, innuendo and flirting. Because of Dr. DaLeigh's "movie star" looks, Dr. DaLeigh has found himself the frequent and aggressive target of such sexual comments. While he has been attracted to many of the females who flirt with him, Dr. DaLeigh has always remained faithful to his girlfriend.

Dr. Sally Uptight, a gifted anesthesiologist, joins the surgery team after her grandfather, who is on the board of directors, convinces her that General St. Hospital is a wholesome place for God to work. Unlike the other females in the operating room, Dr. Uptight grew up in a very conservative and religious household. She is unmarried and never had a boyfriend. She is uncomfortable with the sexual nature of the small talk and gestures in the operating room. The physicians and staff in the operating room believe she is a kill joy and tease her that she was the basis for "The 40-Year Old Virgin" movie. Because Dr. DaLeigh's of nickname, his striking good looks and the sexual comments consistently being directed toward him, Dr. Uptight concludes that Dr. DaLeigh is the ringleader and should be sanctioned. She files a complaint that Dr. DaLeigh has engaged in unprofessional conduct that is disruptive to the safety of patients.

Scenario 2 - Dr. NoNonsense and Nurse Seinfield

Dr. John NoNonsense is a highly skilled and efficient cardiovascular surgeon who has been on the medical staff for over 25 years. His procedures are always textbook, and his rate of negative outcomes remains the lowest of all surgeons on the medical staff. With his patients and their families, Dr. NoNonsense is a always Norman Rockwell portrayal of the paternal, nurturing physician. He genuinely believes that the individual patient always comes first, ahead of any "idiotic hospital bean counter bureaucracy" as he puts it. However, at the hospital, Dr. NoNonsense is serious, methodical and businesslike. His popularity with the hospital staff is mixed. In the operating room, Dr. NoNonsense had a reputation for generously praising hospital personnel for good work and for crucifying those who did not cut muster. Hospital personnel either loved him or hated him, but in either case, respected him for his skills as a surgeon. Dr. NoNonsense believed that "funny business" and humor had no place in the operating room. He also believed that the only competent nurses in the hospital were the "real" nurses in the operating room.

Jerry Seinfield, a nursing supervisor in the pediatrics department, also has been working at the hospital for over 25 years. Unlike Dr. NoNonsense, Nurse Seinfield, with his lighthearted and comic personality, is popular with everyone at the hospital. Nurse Seinfield is a competent supervisor, but his clinical nursing skills are a bit rusty.

Due to a nursing shortage, Nurse Seinfield and other nurses under his supervision, are asked to cover a shift in the cardiovascular wing of the hospital, where he knew that his old high school buddy, Kramer, was post-operative from surgery performed by Dr. NoNonsense. Nurse Seinfield makes an unannounced visit, and while cracking jokes, looks through Kramer's chart (much to the discomfort and embarrassment of Kramer B Kramer has STDs). Dr. NoNonsense then does his rounds and catches the tail end of one of Nurse Seinfield's jokes, which he finds to be extremely distasteful. Then, Dr. NoNonsense verbally orders Nurse Seinfield to administer some medication. Instead of complying, Nurse Seinfield suggests another medication that Nurse Seinfield recently read to be more efficacious. Dr. NoNonsense becomes enraged, and a heated argument between them ensues. Dr. NoNonsense forcibly grabs Nurse Seinfield by forearm (causing some mild bruising) and drags him into the hallway where Dr. NoNonsense proceeds to yell loudly at how stupid and unprofessional Nurse Seinfield was in questioning his order. (In fact, had Nurse Seinfield carefully reviewed the chart, he would have known that his suggestion was completely without merit.)

Embarrassed by the vocal admonition in front of the nurses he supervises and his high school buddy, Kramer, Nurse Seinfield quickly picks up a hospital line and reports to an automated system that Dr. NoNonsense's disruptive behavior amounted to physical and verbal abuse and the creation of a hostile work environment for all nurses on the floor. Nurse Seinfield concludes by saying that "Dr. NoNonsense thinks he knows everything. No one likes him, and he has to be stopped." Two weeks later, Dr. NoNonsense receives a written letter from the surgery department chairman, Dr. Elaine Heavy, asking him to respond to the complaint.

Dr. Heavy sees Dr. NoNonsense in the cafeteria and brings over two cups of coffee. Dr. Heavy broaches the incident with Dr. NoNonsense who responds, "That @#$% nurse shouldn't have been there in the first place. He is incompetent and is full of only jokes. I would have decked him if no one was around. He doesn't think I know, but he's messing around with my wife."

Scenario 3 - Dr. Teamplayer - New Home Inhospitable

Dr. Bill Teamplayer is the only foot and ankle surgeon associated with Hospital Corporation. Hospital Corporation has three hospitals in its geographical area, and Dr. Teamplayer has privileges at all three. Dr. Teamplayer does the majority of his surgeries at Hospital A where the staff adores him. The OR nurses know how he likes his room set up and have it prepared perfectly for each of his cases. The post-op floor nurses know his general prescribing practices for post-op pain and all of his patients do well and complain of little to no pain.

Hospital Corporation realized that there was a large portion of the area's population that find Hospital A difficult to access. The management team decided to ask Dr. Teamplayer to be available to do more cases at Hospital C in order to reach this population. Dr. Teamplayer agreed even though Hospital C is a 30 minute drive from Hospital A and Dr. Teamplayer's home. He feels loyalty to Hospital Corporation because he's been working at Hospital A for years and has bonded with its staff.

Dr. Teamplayer began to operate more at Hospital C. The staff and nurses at Hospital C did not take to Dr. Teamplayer in the same manner that the staff at Hospital A did. Dr. Teamplayer was late to several cases each week, arriving when the patient was already on the OR table being prepped for the case. Because of this, the OR atmosphere seemed frenzied, chaotic and disorganized which made it difficult for the staff to work with Dr. Teamplayer.

The OR nurses were not accustomed to Dr. Teamplayer's preferences for room set-up. Instead of having the foot/ankle to be operated on uncovered, the staff covered the area of operation and left the other foot/ankle uncovered. Several times this caused Dr. Teamplayer to begin surgery on the wrong side. When this happened, he became enraged and yelled at the OR staff that they were harming his patient.

Not only were the OR staff having problems with Dr. Teamplayer, the post-op floor staff encountered some difficulties with his post-op pain prescribing regimen. Unaccustomed to his method of prescribing, several patients suffered from overdoses of pain medication. When this occurred, Dr. Teamplayer would accuse the nursing staff of trying to kill his patient within hearing distance of his patient's room.

ADDITIONAL RESOURCES

Conflict Management Toolkit, American Health Lawyers Association, Jane Reister Conard *et al*., 2008, http://www.healthlawyers.org/Resources/ADR/Documents/ADRToolkit.pdf

Examples of State Law on Peer Review Activities: Confidentiality and Immunity (attached to materials):

DC Law on Peer Review:
- Confidentiality: D.C. CODE ' 44-805 (West 2009).
- Immunity: D.C. CODE ' 44-803 (West 2009).

PA Peer Review Protection Act, 63 PA. STAT. ANN. '' 425.1 *et seq.* (2009):
- Confidentiality: 63 PA. STAT. ANN. ' 425.4 (West 2009).
- Immunity: 63 PA. STAT. ANN. ' 425.3 (West 2009).

VA Law on Peer Review:
- Confidentiality: VA. CODE ANN. ' 8.01-581.17 (West 2009).
- Immunity: VA. CODE ANN. ' 8.01-581.16 (West 2009).

NC Law on Peer Review:
- Confidentiality: N.C. GEN. STAT. '90-21.22A(c) (West 2009).
- Immunity: N.C. GEN. STAT. '90-21.22A(b) (West 2009).