



# New York High Court Clarifies Hospitals' Ability to Address Disruptive Physicians

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Hospital medical staffs throughout the country must occasionally confront the disruptive behavior of one of their members. Aberrant behavior is too often rationalized by claims that a physician is justifiably exercising First Amendment rights of expression, or merely acting as an outspoken advocate for the patients. Hospital administrators and medical staff leadership are reluctant to act, partly for fear that the physician's response will be to start a lawsuit alleging victimization by "sham peer review" in violation of medical staff bylaws, amounting to an actionable breach of contract. Recent decisions by New York's Court of Appeals have significantly bolstered the ability of hospitals and

medical staffs to resolve this problem.

The American Medical Association defines disruptive physician behavior as follows:

*"Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care 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."* (AMA Opinion E-9.045.)

Historically, New York followed a common law rule that no physician has a vested right to use a hospital's facilities for care

and treatment of private patients. Boorish behavior could, therefore, be dealt with expediently, since absent a contractual obligation to the contrary, the physician's continued professional association with the hospital was considered to lie within the unfettered discretion of the hospital's administrators. This rule was tempered by state legislation enacted some 30 years ago, which gave physicians an opportunity to challenge hospital actions that terminate or diminish professional privileges by filing a complaint with the Public Health Council, and in the event the Council failed to direct further hospital review, to apply to the courts for declarative relief concern-

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ing their professional status. However, an increasing number of disgruntled physicians attempted (with mixed success) to bypass this limited administrative remedy by commencing civil actions. Most of these actions contended that medical staff bylaws constitute a binding contract between hospital and physician, which was breached by the disciplinary action at issue.

The confusion caused by inconsistent trial and appellate court decisions on this issue had a chilling effect on hospital quality assurance activities, and encouraged aggrieved physicians to be even more outspoken in exercising their perceived rights. The NY Court of Appeals has now provided some much needed clarity in a recent decision, *Mason v. Central Suffolk Hospital*. In *Mason*, the Court held for the first time that “no action for damages may be based on a violation of medical staff bylaws, unless clear language in the bylaws creates a right to that relief.” In unusually detailed language underscoring the public policy reasons for granting hospital administrators broad discretion, the Court explained:

*“The decisions of our Court, and many of those of the Appellate Division, are consistent with an important, though generally unexpressed policy consideration: it is preferable for hospital administrators to decide whether to grant or deny staff privileges to make those decisions free from a threat of a damages action against the hospital. It is not just in the hospital’s interest, but in the public interest, that no doctor whose skill and judgment are substandard be allowed to treat or operate on patients. A decision by those in charge of a hospital to terminate the privileges of, or deny privileges to, a doctor who may be their colleague will often be difficult. It should not be made more difficult by the fear of subjecting the hospital to monetary liability.”* (3 N.Y.3d 343, 348.)

In a later case, the Court of Appeals used this rule to reject a medical resident’s breach of contract action on a rationale that “residents were not intended to have greater

access to courts than physicians.” *Indemini v. Beth Israel Medical Center*, 4 N.Y.3d 63.

Encouraged by such case law developments, hospital medical staffs have amended their bylaws to define disruptive conduct, and to impose an affirmative duty on all staff physicians to effectively cooperate with their peers. AMA guidelines now address related considerations for internal review processes to verify reports of disruptive behavior. Guidelines have also been developed for corrective measures short of discipline that would affect a physician’s privileges. Such tools have restored, in considerable measure, the traditional authority of hospitals and medical staffs to deal decisively with disruptive physicians. True actionable conduct (such as discrimination, slander, libel or unfair business practices) will continue to provide a viable ground for actions for money dam-

ages. However, the threat of a disgruntled physician successfully suing a hospital for alleged infractions of medical staff bylaws has been all but eliminated.

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