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The Journal of American Physicians and Surgeons, the official peer-reviewed journal of the Association of American Physicians and Surgeons (AAPS), is committed to publishing scholarly articles related to the practice of medicine and to promoting open debate and scientific integrity.

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"Disruptive Physician"

The editorial, "Abuse of the Disruptive Physician Clause,"[1] writes that the term "disruptive physician" is "general, vague, subjective and undefined." The AMA avoids defining disruptive behavior/conduct in its statement on the subject and vaguely refers to consequences, presumed or hypothetical, including potential emotional reactions of others: "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care… includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team."[2]

The AMA's vague concept of "disruptive behavior" enables the hospital administrator to have it both ways: The hospital administrator may improve his own job performance by acting on a physician's advice to improve the quality of care in his hospital, yet predict that the same advice would *negatively* affect patient care, cause emotional reactions in others on the health care team, and disrupt "hospital operations."

The diligent physician has an ethical duty to notify the administrator of his hospital of conditions hazardous to patient welfare or, if the administrator ignores him, to notify external regulatory agencies, even if the notification might anger some emotional members of the "health care team." *Initium est salutis, notitia peccati* (the beginning of improvement is recognition of the error).[3] The hospital administrator should improve those conditions, not charge a diligent physician with "disruptive conduct," as too many do.[4]

The predominance, in the disruptive physician literature, of speculative opinion pieces, devoid of evidence of any link between alleged disruptive conduct and quality of care, is not surprising, given the lack of any definition of the term "quality of care."[5] Courts are under mandate to fashion their decisions in consonance with scientific evidence,[6] so it seems anomalous that no litigant has pursued such an evidence-based argument.

The Supreme Court of Nevada denied peer reviewers civil immunity from Dr. Clark's suit for wrongful revocation of his privileges[7] when it found that they and their hospital had retaliated against him, contrary to good public policy, after he had notified the JCAHO and Nevada's board of medicine of poor practices at his hospital.

Experience confirms the presence in hospitals of arrogant, power-mongering, ethically challenged hospital administrators, nurses, trustees, and healthcare lawyers, yet only one article mentions a prevaricating nurse and only one appellate decision documents thieving trustees, while at least 30 articles and 29 appellate decisions[7,8,9] on "disruptive" physicians have appeared.

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1 Huntoon LR. Abuse of the disruptive physician clause. *J Am Phys Surg* 2004;9:68.
2 Physicians with disruptive behavior. AMA Code of Medical Ethics E-9.045.
3 Seneca. Epistolae XXVIII, 9. In: Summers WC. *Select Letters of Seneca.* MacMillan; 1960.
4 Twedt S. The cost of courage: Part one: How tables turn on doctors. *Pittsburgh Post-Gazette*, Oct 26, 2003, et seq.
5 Grosch EN. Clinical governance is unworkable. *Br J Sports Med* 2004; 38:365.
6 *Daubert v Merrell Dow Pharmaceuticals, Inc.,* 509 US 579 (1993).
7 *Clark v. Columbia/HCA Inform Services, Inc.,* 25 P 3d 215 (Nev 2001).
8 Horty JF. The disruptive physician. *Conn Med* 1985;49:805-19.
9 Casale HM., Springer EW. Hospitals and the disruptive health care practitioner: is the inability to work with others enough to warrant exclusion? 24 *Duq L. R.* 377 (1985).

Pay for Performance

I think that "P for P" is just a euphemism for linking pay to certain desired behaviors. Using electronic medical records (as I do) and saving costs (as I also do) have no direct link with "performance" in terms of the quality of medical care. If we are all electronically linked, however, it is easier for the bureaucracy to control us.

If we all skimp on care, then Medicare saves money (in the short term), and all the risk (for poor outcome or missed diagnosis) is shifted onto the doctors.

I note that *all* of the participating "pilot" programs are either universities or very large managed-care clinic conglomerates–already bureaucratized, and already staffed by their very own doctor employees who need to be "managed."

If we are truly to measure performance, how is it to be done? Who decides the criteria? We can't even decide how to rank football or basketball teams. How can the Center for Medicare and Medicaid Services (CMS) possibly rate doctors?

I predict that, as with the CPT codes, doctors will be rewarded for "documentation," not the actual care given. It cannot be otherwise with a bureaucracy as entrenched as CMS. Get ready for a whole new CPT-like methodology for "rating" doctors, created by a Harvard intelligentsia and lapped up by the AMA.

Why not pay CMS for performance? If their performance continues to be worse than that of Dr. Huntoon's toad, we will have to pay very little.

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Oath of HIPAAcrates

I swear by Teddy, Nancy, Hillary, and Ira, by the Robert Wood Johnson Foundation and all the agencies, departments, gods, and goddesses that, according to my formal compliance plan, I will keep this oath and stipulation: To reckon him/her who brought me into compliance equally dear to me as my parents, to share patient information with him/her upon request, and relieve his/her necessity for command and control as required; to regard his/her officers, functionaries, and bureaucrats as on the same footing with my own brothers, to teach them all they wish to know about my practice and my patients, without fee or stipulation, that by precept, lecture, and every other mode of instruction, I will impart a reverence for the bureaucracy to my own sons and to those of my teachers, and to disciples bound by a formal compliance plan, according to the law of HIPAA, but to none others.

I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of the collective, and abstain from whatever favors any individual. I will give no deadly medicine to anyone, except for excessive resource consumption; furthermore, I will not give to a woman any alternative to abortion.

With loyalty and obedience to the system, I will pass my life and practice my art. I will not cut a person who is suffering with stone, nor give adequate narcotic analgesia, unless for euthanasia, lest I anger the gods of the DEA, but will refer him to an approved tertiary center. Into whatever houses I enter I will go for the benefit of society, as delineated by the regulations of the Center for Medicare and Medicaid Services. I will abstain from every voluntary act of mercy and compassion to the sick; and further from the seduction of females or males, bond or free, except for consenting adults.

Whatever in connection with my professional practice, nor not in connection with it, I may see or hear in the lives of persons which ought not to be spoken abroad I will not divulge, except for reimbursement, research, quality assessment, budgetary planning, or government surveillance, as reckoning that all such should be kept secret from referring physicians, consultants, and those directly concerned with the care of the patient.

While I continue to keep this oath unviolated may it be granted to me to enjoy a closely supervised life and the tightly controlled practice of the art of compliance, respected by all regulatory agencies at all times, but should I trespass and violate this oath, may intimidation, harassment, investigation, indictment, trial, and prison be my lot.

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