[HOSPITAL NAME]
POLICY AND PROCEDURE

Title: Professional Conduct. Prohibition of Behaviors That Undermine a Culture of Safety	
Scope: Hospital-wide	Department: Medical Staff
Source: Medical Staff	Effective Date:

POLICY

All Medical Staff members shall conduct themselves at all times while on Hospital premises in a courteous, professional, respectful, collegial, and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, Allied Health Professionals ("AHP"), nursing and technical personnel, other caregivers, other Hospital personnel, patients, patients' family members and friends, visitors, and others. Such conduct is necessary to promote high quality patient care and to maintain a safe work environment. Behaviors that undermine a culture of safety including behavior which can be construed as discriminatory or harassing, as defined below, are prohibited and will not be tolerated.

Definitions of Types of Behaviors that Undermine a Culture of Safety

A. Behavior that undermines a culture of safety is marked by disrespectful behavior manifested through personal interaction with practitioners, Hospital personnel, patients, family members, or others, which:

1. interferes, or tends to interfere with high quality patient care and patient safety or the orderly administration of the Hospital or the Medical Staff; or

2. creates a hostile work environment; or

3. is directed at a specific person or persons, would reasonably be expected to cause emotional distress, and serves no constructive purpose in advancing the goals of health care.

B. "Discrimination" is conduct directed against any individual (e.g., against another Medical Staff member, AHP, Hospital employee, or patient) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation.

C. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory or sexual-themed cartoons, drawings or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion,

or other aspects of employment; or (2) this conduct interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

D. Other Prohibited Harassment includes behavior which creates a hostile or offensive work environment based upon other protected characteristics, included but not limited to, race, sexual orientation, medical condition or age.

Examples of Prohibited Conduct

Examples of prohibited, disruptive conduct may include, but are not limited to, any of the conduct described below if it is found to interfere, or tend to interfere, with patient care or the orderly administration of the Hospital or Medical Staff; or, if it creates a hostile work environment; or, if it is directed at a specific person or persons, causes physical or emotional distress:

A. Any striking, pushing, or inappropriate touching of Hospital Staff or others;

B. Any conduct that would violate Medical Staff and/or Hospital policies relating to discrimination and/or harassment;

C. Forcefully throwing, hitting, pushing, or slamming objects in an expression of anger or frustration;

D. Yelling, screaming, or using an unduly loud voice directed at patients, Hospital employees, other practitioners, or others;

E. Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient, including, but not limited to, repeated failure to respond to calls or pages;

F. Use of racial, ethnic, epithetic, or derogatory comments, or profanity, directed at Hospital employees or others;

G. Criticism which is unreasonable and unprofessional of Hospital or Medical Staff personnel (including other practitioners), policies or equipment, or other negative comments that undermine patient trust in the Hospital or Medical Staff in the presence or hearing of patients, patients' family members, and/or visitors;

H. Use of medical record entries to criticize Hospital or Medical Staff personnel, policies, or equipment, other practitioners, or others;

I. Unauthorized use and/or disclosure of confidential or personal information related to any employee, patient, practitioner, or other person;

J. Use of threatening or offensive gestures;

K. Intentional filing of false complaints or accusations;

L. Any form of retaliation against a person who has filed a complaint against a practitioner alleging violation of the above standard of conduct;

M. Use of physical or verbal threats to Hospital employees, other practitioners, or others, including, without limitation, threats to get an employee fired or disciplined;

N. Persisting to criticize, or to discuss performance or quality concerns with particular Hospital employees or others after being asked to direct such comments exclusively through other channels;

O. Persisting in contacting a Hospital employee or other person to discuss personal or performance matters after that person or a supervisory person, the Chief Executive Officer ("CEO"), or designee, or Medical Staff leader, has requested that such contacts be discontinued. Medical Staff Members are always encouraged, however, to provide comments, suggestions and recommendations relating to hospital employees, services or facilities, where such information is provided through appropriate administrative or supervisory channels.

P. Obstructing the peer review process by intentionally refusing, without justification, to attend meetings or respond to questions about the practitioner's conduct or professional practice when the practitioner is the subject of a focused review or investigation.

Q. Engaging in intimidating conduct that interferes with an individual's employment or ability to care out their work obligations, or interferes with the patient care team.

PROCEDURE

PROCEDURES FOR RESPONDING TO COMPLAINTS OF BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY INCLUDING DISRUPTIVE BEHAVIOR, DISCRIMINATION, OR HARASSMENT, BY MEDICAL STAFF MEMBERS

I. COMPLAINTS INVOLVING OTHER PRACTITIONERS, PATIENTS, OR VISITORS

All complaints of disruptive behavior, discrimination, or harassment, as defined above made against a Member of the Medical Staff or an allied health professional involving a patient, another Member of the Medical Staff, an AHP, or a visitor to the Hospital (including someone who comes to the Hospital on business) shall be forwarded to: the President/Chief of Staff of the Medical Staff or other appropriate designee ("COS"); the Hospital President or designee such as the Vice President, Medical Affairs; and the Hospital's Director of Risk Management ("DRM"). The Hospital and Medical Staff also may inform their legal counsel. Such complaints shall be handled in accordance with the Medical Staff corrective action procedures set forth in _____ of the Medical Staff Bylaws.

II. COMPLAINTS INVOLVING HOSPITAL PERSONNEL OR VOLUNTEERS

A. INVESTIGATION AND MEDIATION OF COMPLAINTS

1. Allegations

(a) All complaints of behavior that undermines the culture of safety, discrimination or harassment, as defined above, made against a Member or AHP ("Practitioner") and involving hospital personnel or volunteers shall be forwarded, in writing, to either the President/Chief of Staff of the Medical Staff, or the President/Chief of Staff-Elect in the event the allegations involve the President/Chief of Staff of the Medical Staff, and Hospital Human Resources (HR). The report shall include the following:

- Location, date and time of incident
- The individuals involved, including medical staff, employees and a medical record number if a patient was involved in any way
- A factual description of the incident
- If any actions were taken to intervene or remediate, the name, location, date and time of the action
- The consequences of the incident, if any
- Names of witness(es) if any

(b) All such complaints also shall be documented in accordance with the Hospital's Event Reporting system and will be tracked and trended by the Hospital's Quality Management Department. Event Reports shall be maintained as strictly confidential in accordance, and are subject to the attorney-client privilege. In addition, the Medical Staff Office shall maintain a record of all complaints received, and actions taken, utilizing the attached form _____.

(c) Hospital HR and the COS or his/her designee shall advise the President of the Hospital of the complaint and shall keep him/her informed of the status of the investigation to be performed in accordance with the process below. The President or designee shall inform Hospital legal counsel that such a complaint has been received. The COS also may inform the Medical Staff's legal counsel. If the COS determines that the complaint may be valid, and if the behavior presents an immediate risk of harm to any individual, the COS shall take immediate action as may be necessary to protect the patient care environment, and immediately notify the President of the Hospital. If the COS determines that the complaint may be valid, but does not present an immediate risk of harm, and the Hospital President agrees, the COS and HR shall then proceed as provided herein.

(d) The COS and Hospital HR, or their designees, shall each coordinate a prompt initial investigation to determine whether the complaint appears to be supported by reliable evidence. If the COS and Hospital HR find reliable evidence to support the complaint, the COS and Hospital HR shall move forward with the investigation and together

interview all witnesses.

(e) The complaining party shall be informed of the process used to investigate such complaints, and shall also be informed that an oral or written summary of the allegation may be made available to the Practitioner who is the subject of the allegation. The complaining party shall be told to notify his/her department manager or designee and the Hospital HR immediately of any further incidents of prohibited conduct, or any attempt at physical or other types of retaliation. The term "retaliation" does not include a Practitioner's mere denial of alleged misconduct (*i.e.*, a denial that is not accompanied by any improper behavior) or a Practitioner's exercise of any legal rights he/she may have under the Medical Staff Bylaws, these Rules and Regulations, or otherwise.

(f) As part of the initial investigation, the COS shall meet with the Practitioner who is the subject of the complaint to inform him/her that a complaint has been made, and to interview him/her about the allegations in the complaint. The COS shall also advise the Practitioner of his/her obligations under these Rules and Regulations, and that no retaliation against any complaining person, witness, or investigator will be tolerated. The Practitioner should be informed that any attempt at retaliation will be considered an independent ground for corrective action, regardless of the merits of the underlying complaint of prohibited conduct. The Hospital President and President/Chief of Staff of the Medical Staff shall jointly send a letter documenting the Practitioner's legal and medical staff obligations, and the potential individual liability for failing to comply with the law and potential consequences of failing to comply with the Medical Staff Bylaws, Rules, Regulations and Policies.

(g) The COS shall provide the Practitioner with sufficient information to understand and respond to the allegations made by the complaining party. The Practitioner shall be permitted to respond orally or in writing to the allegations. If the Practitioner responds orally, the COS shall document the response in summary format.

(h) Any written statement by the Practitioner and documentation of the investigation created by or submitted to the COS shall be maintained in the Practitioner's peer review file. Event Reports shall not be given to the COS, shall not be used for purposes of peer review, shall be maintained as strictly confidential and are subject to the attorney-client privilege.

(i) The COS and Hospital HR shall take appropriate steps to assure that the complaining party, employees, witnesses and others are protected from disruptive behavior, discrimination or harassment and other prohibited conduct as defined above, as well as retaliation, and that confidentiality of the matter is maintained to the greatest extent possible, pending the resolution of the complaint.

(j) The COS and Hospital HR shall encourage, if feasible, for the parties to agree to an informal resolution of the complaint. If the participants in the initial review agree upon voluntary remedial measures to resolve the complaint, the Practitioner who is the subject of the complaint may be asked to sign a written agreement, which also shall be

signed by the COS, indicating that the Practitioner will comply with those remedial measures. Such an agreement may provide that compliance with its terms is a condition of reappointment. Following such resolution of a complaint through the initial review process, the COS shall monitor the situation for an appropriate period to ensure compliance with the terms of the resolution in such manner as he/she deems most effective.

(k) At the conclusion of the initial investigation and mediation phase, the President/CEO will be provided with a written summary of the results of the initial investigation and efforts at informal resolution. After reviewing the written summary, the President/CEO may request a meeting with the COS to discuss the matter further.

III. COS AND MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION

A. If the parties are unable or unwilling to agree to an informal resolution, or if the Practitioner fails to comply with the informal resolution, the COS may do any or all of the following:

(a) direct the Medical Staff Office to track and trend all reports of inappropriate behavior by the Practitioner for periodic review by the COS;

(b) refer the Practitioner to the Medical Staff Well Being Committee;

(c) refer the Practitioner for psychological evaluation;

(d) in consultation with the Practitioner's Department Chair, refer the Practitioner for appropriate education, such as anger management training;

(e) issue a letter of instruction, admonition, or warning; and/or

(f) ask the MEC to initiate a formal corrective action investigation of the complaint in accordance with Article __, Section ___ of the Medical Staff Bylaws.

B. If the MEC initiates a corrective action investigation of the complaint, it shall appoint an Investigating Committee (IC) in accordance with Section ____ of the Medical Staff Bylaws.

(a) If the complainant or the affected Practitioner is a female, the IC shall include at least one female member. If the Practitioner under investigation is an AHP, then one member of the IC shall be a member of the AHP staff.

(b) The IC may, and if the complainant is a Hospital employee, it shall, include as a member the Hospital HR or designee.

(c) The IC shall have access to the documents from the initial investigation/mediation process, and shall also document its own investigation.

(d) At the conclusion of the investigation, the IC shall report its findings and recommendation(s) to the MEC, which shall proceed in accordance with Article __, Section ___ of the Medical Staff Bylaws.

IV. ACTION BY THE PRESIDENT/CEO AND BOARD

If the COS asks the MEC to initiate a corrective action investigation but the MEC elects not to do so, the President shall be entitled to request that the Board of Directors direct the Medical Staff to take further action in accordance with the provisions of Medical Staff Bylaws and applicable law. Nothing set forth herein is intended to supplant or modify the Board of Director's rights regarding corrective action as set forth in the Bylaws Article ___, Section ___

V. TRENDING OF COMPLAINTS

All events that result in complaints about physician behavior that undermines a culture of safety, and all related follow-up actions, will be tracked by the Hospital Quality Management Department ("QMD"). Trend reports will be reviewed on a regular basis by the President/Chief of Staff of the Medical Staff to determine if physician-specific behavior issues persist over time. Two (2) or more events during a one-year period for any Medical Staff member will trigger review of his/her trend report by the President/Chief of Staff of the Medical Staff (or his/her designee) and consideration of the need for further investigation and/or action in accordance with the Bylaws and these Rules by the MEC. If the President/Chief of Staff of the Medical Staff determines that a behavior trend has been identified, such a behavior trend will result in a meeting with the involved physician and one or more Medical Staff leader(s) appointed by the President/Chief of Staff of the Medical Staff to review the reported events, communicate behavior expectations, and formulate a follow-up plan. All reports of complaints involving a Practitioner shall be considered at the time of the Practitioner's reappointment process.

VI. MONITORING THE EFFECTIVENESS OF THIS POLICY

On no less than an annual basis the Medical Staff shall review this Policy to determine the effectiveness of the Policy and modify the Policy as may be necessary to assure the effectiveness of the Policy in maintaining a culture of safety at the Hospital.