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**Policy Title: Medical Staff Code of Conduct**

**Policy Number:**

EFFECTIVE DATE: *November 2005*

POLICY TITLE: Medical Staff Code of Conduct

**LOCATION(S) Policy is Applicable to:**

\_\_ Saint Francis Hospital and Medical Center

\_\_ Mount Sinai Rehabilitation Hospital

\_\_ Johnson Memorial Hospital, Inc.

\_\_ The Mercy Hospital, Inc.

\_\_ Saint Mary’s Hospital, Inc.

***To be reviewed every three years by:***

**Medical Executive Committee**

**\_X\_\_ REVIEW BY: *July 2020***

**POLICY**

1. **Policy Statement**
   1. All Medical Staff members practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.
2. This Policy outlines collegial and educational efforts to be used by Medical Staff leaders in order to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the disciplinary process in the Credentialing Policy.
3. This Policy is intended to address sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.
4. In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.
5. All efforts undertaken pursuant to this Policy shall be part of the Hospital's performance improvement and professional and peer review activities.
6. **Definition and Examples of Inappropriate Conduct**

To aid in both the collegial education of Medical Staff members and in the enforcement

of this Policy, examples of “inappropriate conduct" include, but are not limited to:

* + - threatening or abusive language directed at patients, nurses, Hospital personnel, or other physicians (e.g. belittling, berating, and/or threatening another individual);
  + degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;
  + Profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel.
  + inappropriate physical contact with another individual that is threatening or intimidating;
* derogatory comments about the quality of care being provided by the Hospital, another Medical Staff member, or any other individual or otherwise critical of the Hospital, another Medical Staff member, or any other individual that are made outside of appropriate Medical Staff and/or administrative channels;
* inappropriate medical record entries that are derogatory in nature, concerning the quality of care being provided by the Hospital, and other Medical Staff members or personnel;
* refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentialing Policy, and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and the Hospital Staff); and/or
* "Sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:

1. Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;
2. Visual/Non-Verbal: derogatory posters, cartoons, e-mails, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;
3. Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and
4. Other: making or threatening retaliation as a result of any individual's negative response to harassing conduct.
5. **General Guidelines/Principles**
6. Issues of employee conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Issues of conduct by any member of the Medical Staff (hereinafter referred to as "practitioner") will be addressed in accordance with this Policy.
7. Every effort will be made to coordinate the actions contemplated in this Policy with the provisions of the Credentialing Policy. In the event of any apparent or actual conflict between the Policy and the Credentialing Policy, the provisions of this Policy shall control.
8. This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken in an attempt to resolve complaints about inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing this Policy precludes an immediate referral to the Medical Executive Committee or the elimination of any particular step in the Policy when dealing with a complaint about inappropriate conduct.
9. The Medical Staff leadership and Hospital Administration shall provide orientation and education to make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy prohibiting sexual harassment and requiring respectful, dignified conduct. The Medical Staff leadership and Hospital Administration shall institute procedures to facilitate prompt reporting of conduct which may violate the Policy and prompt action as appropriate under the circumstances.
10. **Procedure When a Concern is Raised**

1. Nurses and other Hospital employees who observe, or are subjected to, inappropriate conduct by a practitioner shall notify their Supervisor about the incident or, if their Supervisor's behavior is at issue, they shall notify the Chief of Staff and/or the Chief Executive Officer. Any practitioner who observes such behavior by another practitioner shall notify the Chief of Staff or the Chief Executive Officer. Upon learning of an occurrence of an incident of appropriate conduct, the Supervisor, Chief of Staff, or Chief Executive Officer shall request that the individual who reported the incident document it in writing. In the alternative, if the employee or practitioner who observed or was subject to the inappropriate conduct refuses to document the incident for fear of retaliation or other legitimate concern, the Supervisor, Chief of Staff, or Chief Executive Officer may document the incident as reported.

* 1. The documentation should include:
     1. the date and time of the incident;
     2. a factual description of the questionable behavior;
     3. the name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident.
     4. the circumstances which precipitated the incident;
     5. The names of other witnesses to the incident;
     6. consequences, if any, of the behavior as it relates to patient care, personnel, or Hospital operations;
     7. any action taken to intervene in, or remedy, the incident; and
     8. the name and signature of the individual reporting the complaint of inappropriate conduct.
  2. The Supervisor, Chief of Staff, or Chief Executive Officer shall forward the report to the relevant Department Chairperson and shall discuss with the Department Chairperson how best to proceed, including meeting with the individual who prepared the report and/or any witnesses to the incident to asce1tain the details of the incident.
  3. If the Chief of Staff and the relevant Department Chairperson determine that an incident of inappropriate conduct has likely occurred, they have several options available, including,

but not limited to the following:

* + - notify the practitioner that a complaint has been received and meet with the practitioner to obtain more information about the incident;
* meet with the practitioner to counsel and educate the individual about the concerns and the necessity to modify the behavior in question;
* send the practitioner a letter of guidance about the incident;
* send the practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing; and/or
* refer the matter to the Medical Executive Committee.

These efforts by the Chief of Staff and/or the relevant Department Chairperson are intended to be collegial, with the goal of being helpful to the practitioner in understanding that certain conduct is inappropriate and unacceptable.

* 1. These efforts can also be used to educate the practitioner about administrative channels that are available for registering complaints or concerns about quality or services, if the practitioner's conduct suggests that such concerns led to the behavior. Other sources of support or counseling can also be identified for the practitioner, as appropriate.
  2. The identity of an individual reporting a complaint or inappropriate conduct will generally not be disclosed to the practitioner during these efforts, unless the Chief of Staff and the relevant Department Chairperson agree that it is appropriate to do so. In any case, the practitioner shall be advised that any retaliation against the person reporting a concern, whether the specific identify is disclosed or not will be grounds for immediate disciplinary action pursuant to the Credentialing Policy.
  3. If the Chief of Staff and/or the relevant Department Chairperson prepare any documentation for a practitioner's confidential department file regarding efforts to address concerns with the practitioner, the practitioner shall be apprised of that documentation and given an opportunity to respond in writing. Any such response shall then be kept in the practitioner's confidential department file.
  4. If additional complaints are received concerning a practitioner, the Chief of Staff and the relevant Department Chairperson may continue to utilize the collegial and educational steps noted in this Policy as long as they believe that there is still a reasonable likelihood that those efforts will resolve the concerns. The Chief Executive Officer shall be kept apprised of any additional complaints. At any point in this process, the matter may be referred to the Medical Executive Committee in accordance with the Credentialing Policy.
  5. In order to effectuate the objectives of this Policy, and except as otherwise may be determined by the Chief of Staff and the relevant Department Chairperson, the practitioner's counsel shall not attend any of the meetings described in this Policy.

**Sexual Harassment Concerns:**

1. Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the action set forth in Paragraphs 11-13 of this Policy.

2. A meeting shall be held with the practitioner to discuss the incident. If the practitioner has agreed to stop the conduct thought specifically to constitute sexual harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the practitioner's confidential department file. This letter shall also set forth those additional actions, if any, that result from the meeting.

3. If the practitioner refuses to agree to stop the conduct immediately, this refusal shall result in the matter being referred to the Medical Executive Committee to be formally investigated pursuant to the Credentials Policy.

4. Any reports of retaliation or any further reports of sexual harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate investigation by the Medical Executive Committee.

**RESPONSIBLE DEPARTMENT:** Medical Executive Committee

**APPROVALS**

**Initial Approval:** 11/2005