Practitioner/APP Professional Conduct Policy

BETHESDA HOSPITAL

A Medical Staff Document

I. INTRODUCTION

A. The Medical Staff adopts the Professional Code of Conduct, a copy of which is attached hereto as Exhibit A and incorporated by reference herein, and this Practitioner [1] Conduct Policy (collectively, the "Policy") to define conduct expectations and to provide a procedure to assist the Medical Staff in dealing with Practitioners who engage in unprofessional conduct at the Hospital.

B. All Practitioners agree, as a condition of their appointment and/or Privileges, to abide by the Medical Staff Bylaws or the Advanced Practice Provider (APP) Policy, as applicable, in addition to applicable Hospital/Medical Staff policies and procedures. To that end, the Hospital requires all Practitioners to conduct themselves in a professional and cooperative manner.

C. This Policy is intended to address those situations in which collegial intervention, in lieu of initiation of formal corrective action proceedings, may be sufficient. This Policy provides collegial steps and educational/remedial efforts that can be taken to address Practitioners who fail to conduct themselves in a professional manner. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve the concerns that have been raised.

D. Nothing in this Policy should be construed as requiring its implementation prior to any action that might otherwise be taken pursuant to the Medical Staff Bylaws or APP Policy, as applicable, including initiation of formal corrective action against a Practitioner on the basis of a single incident of inappropriate behavior or continuation of such conduct.

E. This Policy does not preclude any person authorized to impose a summary suspension pursuant to the Medical Staff Bylaws or APP Policy, as applicable, from doing so; nor, does this Policy preclude an authorized individual from summarily suspending a Practitioner pursuant to the Medical Staff Bylaws or APP Policy based upon information that the authorized individual learns as a result of this Policy. The authorized individual imposing such summary suspension will not be precluded from continuing as a participant in the procedure set forth in this Policy.

F. Terms used in this Policy will have the same meaning as set forth in the Medical Staff Bylaws or APP Policy, as applicable, unless a different definition is provided in this Policy.

G. Wherever a position or title is used in the Medical Staff Bylaws or Policies, the authorized designee (*i.e.,* substitute) of the person holding that position or title is included in the term.

[1] For purposes of this Policy, the term "Practitioner" will include Physicians, Dentists, Podiatrists, Psychologists, and Advanced Practice Providers (APP) (*e.g.,* advanced practice registered nurses, physician assistants, *etc.*) granted Clinical Privileges at the Hospital.

II. DEFINITION/EXAMPLES OF UNPROFESSIONAL CONDUCT

A. For purposes of this Policy, the term "unprofessional conduct" means disruptive behavior that undermines a culture of safety.

B. Unprofessional conduct includes, but is not limited to, the following:

1. Impertinent or inappropriate comments to patients, other Practitioners, or Hospital staff; or, entries/illustrations in medical records or other official documents that impugn the quality of care delivered, attack individuals, or are unprofessional.

2. Sexual, ethnic, or other types of unlawful discrimination or harassment whether written, verbal, or physical in nature.

3. Criticism presented in such a way as to blame, intimidate, threaten, humiliate, belittle, or impute stupidity or incompetence of others.

4. Refusal to participate and cooperate in Medical Staff or APP functions or to do so in a disruptive manner.

5. Repeated or deliberate violation of the Medical Staff Bylaws, APP or other Medical Staff Policies, or Hospital policies.

6. Unprofessional, pejorative, or abusive behavior toward patients, members of their families, Hospital visitors, Hospital staff, or other Practitioners including, but not limited to, refusing to listen to legitimate questions, concerns, or requests.

7. Imposing unreasonable requirements on other Practitioners or Hospital staff.

8. Inappropriate behavior as a result of physical or mental impairment.

9. Threatening or intimidating physical contact or attacks leveled at other Practitioners, Hospital staff, or patients (*e.g.*, throwing objects, *etc.*).

10. Intimidation or retribution against any patient, a patient's family member, another Practitioner, or Hospital employee who reports or witnesses a Practitioner's unprofessional conduct; or, protecting any person who refuses to cooperate in review of a Practitioner.

III. REPORT AND DOCUMENTATION OF UNPROFESSIONAL CONDUCT; ASSIGNMENT OF REPORT

A. REPORTING/DOCUMENTATION PROCEDURE

1. Individuals who witness incidents of unprofessional conduct by Practitioners should complete and submit a Hospital incident report or otherwise document the incident. Reporting should be done in a prompt manner.

2. If an individual provides a verbal report to his/her supervisor but declines to reduce it to writing, it is the responsibility of the supervisor to do so.

3. If an individual provides a report to a member of Medical Staff leadership but declines to reduce it to writing, it is the responsibility of the Medical Staff leader to do so.

4. In the event that documentation is provided in a form other than an incident report, such documentation should include the/a:

   (a) Date and time of the incident.

   (b) Factual description of the incident.

   (c) Name/position of anyone who was involved in the incident.

   (d) Circumstances that precipitated the incident.

   (e) Consequences, if any, related to patient care or Hospital operations.

   (f) Action taken to intervene or remedy the incident.

   (g) Name and date of the individual submitting the report.

B. ASSIGNMENT OF REPORT

1. It is the expectation that Hospital incident reports (or other written documentation) that allege(s) unprofessional Practitioner conduct be directed to the Chief Medical Officer (CMO) or Associate Chief Medical Officer (Associate CMO), as a member and/or authorized agent of the Practitioner Effectiveness Committee (PEC), and addressed by the PEC pursuant to this Policy as part of the peer review process.

2. In the event that the allegation of unprofessional conduct involves a Practitioner employed by TriHealth Physician Practices, LLC (TPP) the CMO or Associate CMO shall decide whether the TPP peer review committee should also be notified.

   (a) If such referral is made, the PEC shall be advised.

   (b) The PEC may either proceed with its review or hold its review in abeyance until review by the TPP peer review committee is complete.

3. In the event that an allegation of unprofessional conduct involves a claim of discrimination or harassment by a Practitioner, the CMO or Associate CMO shall notify the Hospital's Human Resources Department to conduct an investigation of such allegation.

(a) The PEC shall defer its review of the conduct matter until Human Resources completes its investigation of the harassment/discrimination allegation.

(b) The PEC will be advised of the findings made by Human Resources with respect to the discrimination/harassment allegation.

(c) The PEC shall decide what action should be taken pursuant to this Policy or the Medical Staff Bylaws or APP Policy, as applicable, upon receipt of Human Resource's report.

4. This Policy does not govern the process that is followed in the event a matter is referred to Human Resources. Rather, this Policy is limited to the process to be followed in the event a matter regarding unprofessional Practitioner conduct is handled by the Medical Staff as a Medical Staff matter.

5. Human Resources will not be provided with any information compiled or reviewed by the MEC, PEC, or other peer review committee as part of a protected peer review process unless otherwise determined by the CMO or Associate CMO and Medical Staff President in consultation with Hospital counsel.

C. ANONYMOUS REPORT

1. Although knowledge of the reporting individual's identity is preferred for purposes of follow up, reports of unprofessional conduct may be made anonymously.

2. The fact that a report is anonymous will not preclude the matter from being reviewed in accordance with the procedure set forth in this Policy; however, the fact of anonymity means that it may not be possible to validate the concerns and that no response back to the concerned individual will be able to be made.

D. NO RETALIATION

1. No individual who, in good faith, reports a Practitioner's unprofessional conduct or who otherwise participates in the procedure set forth herein will be retaliated against for such report or participation.

2. The party who makes an allegation of unprofessional conduct will be advised when follow-up action has been taken but will not be provided with specific details of the resolution.

IV. PEC REVIEW OF REPORT OF UNPROFESSIONAL CONDUCT

A. The composition and related information regarding the PEC is set forth in the Medical Staff Organization Policy.

B. Reviews may be conducted by the PEC as a whole or a review may be assigned to one or more PEC members and/or other designated PEC agents (*e.g.,* a Medical Staff officer, Department Chair, *etc.*) to report back to the PEC. **For purposes of this Policy, a reference to the PEC will include the PEC's members and other designated agent(s).**

1. Upon receipt of a report of unprofessional conduct by a Practitioner, the PEC chair shall:

(a) Convene the PEC to review the matter pursuant to the procedure set forth in this Policy.

OR

(b) Assign the matter to a PEC member(s) and/or other designated PEC agent(s) for review and report back to the PEC.

2. If, at any time, the PEC reasonably believes that the behavior of the Practitioner may be related to health or impairment concerns, the PEC may consider whether the matter should continue to be handled pursuant to this Policy or pursuant to the procedure set forth in the Practitioner Impairment Policy.

C. Each report should be sufficiently considered to determine whether the report has validity. This assessment should consist of:

1. Reviewing documents and talking with individuals (including the complainant and the Practitioner as appropriate). Individuals who are interviewed will be reminded that this is a confidential peer review process and that the discussion may not be disclosed to others.

2. Determining whether the report reflects a first-time issue or whether there have been any prior incidents, or formal or collegial interventions with the Practitioner, in order to determine whether a pattern or trend is developing or has developed.

D. In the event that a member of the PEC is the Practitioner who is the subject of the report or otherwise has a conflict of interest with respect to the Practitioner who is the subject of the report, another Practitioner may be appointed to participate in review of the matter and the PEC member who has a conflict of interest or who is the subject of the report will not participate in the PEC proceedings as a PEC member.

E. The PEC may notify the Practitioner upon receipt of a report of unprofessional conduct; however, such notification is not required prior to proceeding with review of the matter.

F. The PEC will rely upon the most recent complaint of unprofessional conduct in its review of the event; provided, however, that consideration of reports of past incidents, if any, received may also be considered.

V. PRACTITIONER'S RIGHTS

A. Engagement with the PEC is voluntary. A Practitioner has the right to refuse to participate in the process.

B. A Practitioner has the right to respond, in writing, to allegations raised in a report of unprofessional conduct or to otherwise respond to any communication that the Practitioner receives from the PEC. All written responses will be maintained in the Practitioner's quality file.

VI. ACTION FOLLOWING CONCLUSION OF PEC REVIEW

A. If the PEC determines that a report of unprofessional conduct lacks validity, the matter will be closed. The fact that the report was filed and closed based upon lack of validity will be documented by the PEC in its minutes and a note to such effect will be maintained in the Practitioner's quality file.

B. If the PEC determines that a report of unprofessional conduct can be resolved by a collegial conversation with the Practitioner, the PEC will designate the individuals who should have such meeting with the Practitioner. The preference will be for the meeting to be held by two (2) or more members of the PEC unless circumstances dictate otherwise. The fact of the meeting will be reported back to the PEC and documented in a follow up letter provided to the Practitioner with a copy of such letter placed in the Practitioner's quality file.

C. If the PEC determines that the report of unprofessional conduct raises a significant concern or that the Practitioner is developing a trend or pattern of unprofessional conduct, the PEC may engage in one or more of the following activities:

1. Request that the Practitioner meet with the PEC.

2. Suggest/encourage the Practitioner to engage in remediation activities (*e.g.*, anger management, counseling, boundaries education, *etc.*).

3. Issue a letter of warning to the Practitioner.

4. Develop a voluntary remediation plan with the Practitioner.

5. Refer the matter to the Medical Executive Committee for initiation of formal corrective action pursuant to the procedure set forth in the Medical Staff Bylaws or APP Policy, as applicable.

6. Such other action as is appropriate to the circumstances.

D. The PEC may continue to utilize the collegial and educational steps set forth in this Policy as long as the PEC believes that there is a reasonable likelihood that such efforts will resolve the concerns.

E. All meetings with a Practitioner (whether with a member(s) of the PEC, one or more persons designated by the PEC, or the committee itself) should include a clear statement to the Practitioner that if the unprofessional conduct continues, the matter will be referred to the Medical Executive Committee for initiation of the formal corrective action process.

F. If the PEC recommends a course of action but the Practitioner refuses to accept the PEC's recommendation or to otherwise comply with the requirements of this Policy, such refusal will be reported by the PEC to the Medical Executive Committee (for consideration as to whether formal corrective action should be initiated), the System CEO, CMO or Associate CMO, Medical Staff President; and, if required, to the State Medical Board of Ohio, the Ohio Board of Nursing, or other appropriate state licensing agency.

G. If the PEC at any time deems formal corrective action to be warranted, the PEC will make such recommendation to the Medical Executive Committee consistent with this Policy and in accordance with the procedure set forth in the Medical Staff Bylaws or APP Policy, as applicable.

H. Unless corrective action is recommended, the PEC shall not be required to obtain the approval of the MEC with respect to any arrangements agreed to by the PEC and the Practitioner.

VII. REPORTING REQUIREMENTS

A. The System CEO, CMO or Associate CMO, and Medical Staff President will be notified prior to any reporting that is required by applicable laws, rules, and/or regulations of actions taken with regard to a Practitioner or information related to a Practitioner.

B. Any reports of criminal activity required by applicable laws, rules, and/or regulations will be reported immediately to the System CEO, CMO or Associate CMO, and Medical Staff President for reporting to the appropriate authorities.

C. Hospital legal counsel will be consulted prior to any such reporting.

VIII. EDUCATION

Education for the Medical Staff and other healthcare professionals will be provided regarding this Policy as needed. Such education will include, without limitation: the content of this Policy and the fact that it will be enforced, behavior expectations and the importance of adhering to standards of professional conduct, how to identify and resolve conflict, examples of unprofessional conduct, and the process for reporting, self-reporting, and addressing unprofessional conduct.

IX. SELF-REPORTING ENCOURAGED

Practitioners are encouraged to voluntarily self-report conduct issues to a member of the PEC or a Medical Staff leader for assistance so that appropriate steps can be taken to protect patients and help the Practitioner regain and retain the ability to practice safely and competently.

X. CONFIDENTIALITY AND IMMUNITY

A. All documentation pursuant to this Policy including letters, notes, reports, minutes, or other writings or communications submitted to or generated by the PEC will be appropriately labeled and treated as confidential/privileged peer review documents protected from discovery by Ohio Revised Code §2305.25 *et seq.* to the full extent permitted by law and will be retained in the Practitioner's quality file and/or in such other peer review committee files, as appropriate, maintained in the Quality Department, the Medical Staff Services Department, or other appropriate secure location.

B. The identity of individuals providing information to the PEC and all information provided by such individuals, whether written or oral, will be maintained as confidential peer review information to the full extent permitted by law.

C. It is the intent of the Hospital and the Medical Staff that the members/other agents of the PEC and all individuals providing information to the PEC will be deemed to be engaged in a peer review activity and entitled to immunity to the full extent permitted by law.

D. All parties involved in the procedure set forth in this Policy will maintain confidentiality and will not discuss the matter with anyone other than as needed to fulfill their obligations under this Policy.

E. The files of the PEC will be made available to the Credentials Committee and Medical Executive Committee to the extent such files contain information relevant to an application for, as applicable, Medical Staff reappointment and/or regrant of Privileges.

F. If the PEC at any time deems formal corrective action to be warranted, the PEC will make such recommendation to the Medical Executive Committee consistent

with this Policy and in accordance with the procedure set forth in the Medical Staff Bylaws or APP Policy, as applicable.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on:

Approved by the Board on:

Effective:

PROCESS OVERVIEW

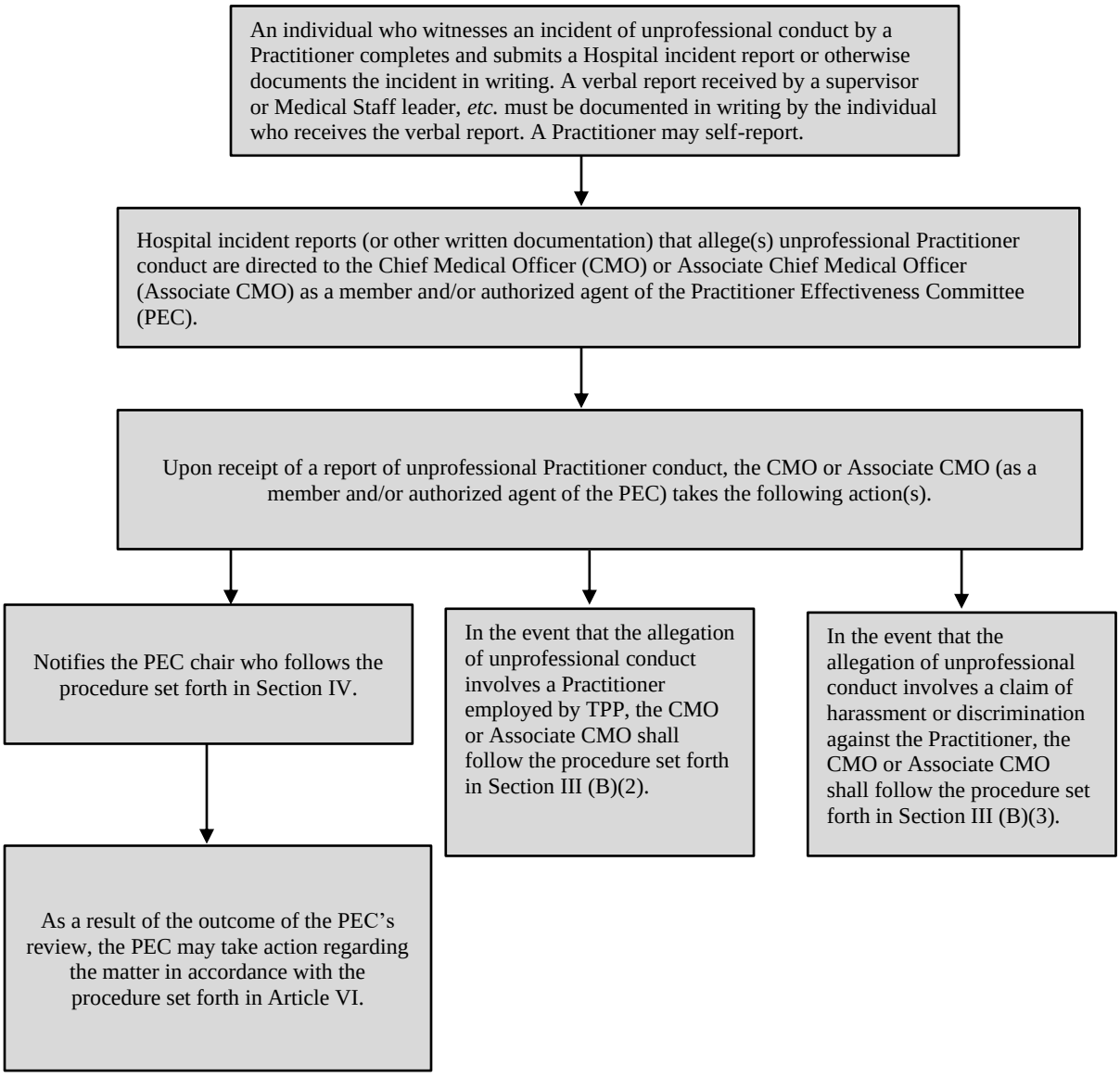

EXHIBIT A

PRACTITIONER/ADVANCED PRACTICE PROVIDER CODE OF CONDUCT

Quality of Clinical Practice

- Practice consistent with current standards of care.
- Maintain and expand skills and knowledge to meet evolving standards of care now and in the future.
- Participate regularly in peer case reviews to help self and others constantly improve professional practice.
- Treat all individuals with courtesy, dignity, and respect.
- Engage in professional, honest, and ethical behavior.
- Document appropriately (*i.e.*, in a professional manner) in medical records.

Quality of Patient Relations

- Guide patients and families through end-of-life challenges with compassion & support.
- Discourage futile care when recognized.
- Treat all patients with courtesy, dignity, and respect.
- Be known as a good and caring listener.
- Communicate clearly to the patient and family irrespective of their background or education level.
- Respect the customs and practices of patients.
- Uphold patient confidentiality and confidential information such as peer review discussions.

Quality of Collegial Relations

- Treat colleagues, consultants, nurses and other clinical/support staff with respect as team members working to care for patients.
- Answer calls, pages, *etc.* asking for help, advice, and/or consultation promptly and within agreed time limits.
- Mentor and help less experienced members of the team.
- Handle disagreements civilly, professionally, and through established mechanisms. Seek to understand where processes may have failed.
- Take your share of call (as applicable); it's both a privilege and a duty. Treat insured and uninsured call patients equitably; mid-day or midnight.
- Use Hospital property, facilities, equipment, and supplies for professional activities not personal use.
- Use personal property such as, but not limited to, electronic devices (*e.g.*, cell phones, cameras, flash drives, notebooks, laptops, *etc.*) in accordance with applicable System, Hospital, and/or Medical Staff policies.
- Address any criticisms of, or concerns about, your colleagues, APPs, or Hospital staff to the appropriate Medical Staff leader or Hospital supervisor, as applicable, in a courteous manner and in private.
- Refrain from the use of profanity or other offensive language while on Hospital premises.

- Do not knowingly disseminate information that is false, misleading, or deceptive regarding the Hospital or individuals associated with the Hospital.
- Refrain from language or actions that are or could be construed as discriminatory or as harassing including, but not limited to, sexual harassment (*e.g.*, such as unwelcome sexual advances, requests for sexual favors, and/or other verbal and physical conduct of a sexual nature).
- Abide by the Medical Staff governing documents and applicable Hospital policies and procedures.

Share your Talents

- Participate in the activities of the Medical Staff including committees, peer review, and quality improvement efforts.
- Be open to participation in other community and public service needs. Your education and experience are rare commodities.

I have read and understand the Practitioner/APP Professional Conduct Policy and agree to abide by its terms.

_____ _____

Signature Date

_____

Please Print Name