GUIDING PRINCIPLES

All Medical Staff members practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional, collaborative, and cooperative manner. 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.

PURPOSE

1. To outline 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 as delineated in Article X of the Medical Staff Bylaws.

2. To address sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.

3. To prevent or eliminate (to the extent possible) conduct that:
   • disrupts the operation of the hospital;
   • affects the ability of others to do their jobs;
   • creates a “hostile work environment” for hospital employees or other medical staff members;
   • interferes with an individual's ability to practice competently; or
   • adversely affects or impacts the community’s confidence in the hospital’s ability to provide quality patient care.

4. To promote a "Just Culture" and thereby a culture of respect which improves patient safety.

DEFINITIONS 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:
• use of language or gestures that is objectively threatening, intimidating, or abusive and directed at patients, nurses, Hospital personnel, or other physicians (e.g., belittling, berating, implication of stupidity/incompetence, and/or threatening another individual) or is otherwise disruptive;
• use of any derogatory or belittling language (verbal or written) related to race, color, religion, sex, national origin, age, familial status, disability, or sexual and gender orientation;
• degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;
• impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, that impugn the quality of care being provided in the Hospital or is otherwise embarrassing or potentially embarrassing to the Hospital or is critical of the Hospital, other Medical Staff members, personnel, or hospital policies;
• profanity or similarly offensive language while in the Hospital and/or while speaking with nurses, other Hospital personnel, patients, or others;
• inappropriate physical contact with another individual that is threatening or intimidating;
• words or actions that prevent or interfere with an individual's or group's work, academic performance, or ability to achieve intended outcomes (e.g., intentionally ignoring questions or not returning phone calls or pages related to matters involving patient care);
• public 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 including criticism leveled at the recipient in such a way that it intimidates, undermines confidence, belittles, or implies stupidity or incompetence;
• refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, and an unwillingness to work cooperatively and harmoniously with other members of the Medical and Hospital Staffs);
• throwing instruments, charts and other physical items; 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:

(a) **Verbal:** innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

(b) **Visual/Non-Verbal:** derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;

(c) **Physical:** unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and

(d) **Other:** making or threatening retaliation as a result of an individual's negative response to harassing conduct.
GENERAL GUIDELINES

1. Issues of employee conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Issues of conduct by members of the Medical Staff (hereinafter referred to as "practitioners") will be addressed in accordance with this Policy.

2. 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 exhibited by practitioners. However, there may be a single incident of 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 in 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. A single egregious incident, such as (but not limited to) physical or sexual harassment, assault, a felony conviction, a fraudulent act, stealing, damaging hospital property, or inappropriate physical behavior, may result in immediate termination of employment or medical staff membership.

3. 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 this Policy and prompt action as appropriate under the circumstances.

4. All medical staff members and applicants for medical staff membership will be required to formally attest that they have received a copy of this policy and procedure and agree to comply with the requirements as stated. Reaffirmation of this agreement will be required at the time of reappointment.

5. Although each practitioner is expected to take responsibility for his/her own actions, all medical staff members share responsibility to support a culture of collegiality and excellence. This includes consistently responding to disruptive behavior they witness or of which they become aware. Appropriate responses depend on the specific behaviors and circumstances, however, all medical staff members are encouraged to intervene with each other to provide quick feedback ("I saw", "I observed", "I heard") when a lapse in professionalism is encountered.

6. The Medical Staff supports recognition of exemplary behavior demonstrated by practitioners who serve as role models in promoting professional behavior that enhances patient safety and quality outcomes.

7. Any member of the Medical Staff who has questions or concerns about this policy should contact the Chief Medical Officer or his/her designee.
PROCEDURE WHEN A CONCERN IS RAISED

1. Any medical staff member, advanced practice professional, employee, patient or visitor may report potentially unprofessional conduct to his or her immediate supervisor or to Medical Administration. A supervisor or member of Medical Administration in possession of such a report shall ensure that a documented report regarding the matter is submitted to the Chief Medical Officer or his/her designee.

2. Documentation of disruptive conduct is critical since it is ordinarily not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. That documentation shall include:

   (a) the date and time of the questionable behavior;

   (b) if the behavior affected or involved a patient in any way, the name of the patient;

   (c) the circumstances surrounding the incident, including any predisposing or precipitating factor(s);

   (d) a description of the questionable behavior limited to factual, objective language as much as possible;

   (e) the consequences, if any, of the behavior as it relates to patient care, personnel, or Hospital operations;

   (f) record of any action taken to remedy the situation including date, time, place, action and name(s) of those intervening;

   (g) the name and signature of the individual reporting the complaint of inappropriate conduct.

3. In general, a step-wise "tiered" intervention process that aims to promote accountability, insight (ownership), and behavior change (restoration) as outlined below will be followed to address complaints of inappropriate conduct or patterns of disruptive behavior.

   (a) The Chief Medical Officer, or his/her designee, will investigate the complaint for validity in consultation with the Chief of Staff and/or the respective Department Chair.

   (b) If the Chief Medical Officer or designee determines the complaint is unfounded and/or irrelevant, it will be dismissed with no record kept in the practitioner's confidential peer review file.

   (c) If the Chief Medical Officer or designee determines, after the investigation and in consultation with the Chief of Staff and/or Department Chair, that the complaint is well founded, the first intervention will be an informal conversation with the practitioner by the
Chief Medical Officer, Chief of Staff, or a designee selected by either of them, that is collegial and supportive but emphasizes that such behavior is unprofessional and promotes an unsafe culture and must cease. This "cup-of-coffee" discussion shall be documented with a copy of the written summary retained in the practitioner’s confidential peer review file.

The practitioner will be informed that any attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question is a violation of this policy and grounds for further disciplinary action in accordance with the MHM Medical Staff Bylaws.

(d) Complaints of disruptive or unprofessional behavior may aggregate over time. Each validated complaint and the steps taken to address the concerns raised will be documented with a copy of the written summary retained in the practitioner’s confidential peer review file. Each incident warrants a discussion between the involved practitioner and the Chief Medical Officer or designee to explain the necessity of complying with this policy.

(e) If it appears to the Chief Medical Officer or designee that a recurring pattern of unprofessional conduct is developing, or has developed, the practitioner will be requested to attend their respective departmental peer review meeting by the Chief of Staff and/or Department Chair. A copy of this policy will be shared with the practitioner in conjunction with a discussion of the specific unacceptable conduct that is the subject of the complaint. The practitioner will be afforded an opportunity to explain their behavioral choices and to develop a plan of action to prevent such behavior from recurring (the START intervention as outlined in the Just Culture Algorithm).

Remediation measures could include such components as stress/anger management training, counseling/psychotherapy, tutorial sessions, monitoring, teamwork training, leadership training, an apology, delineation of specific expectations for behavior going forward and consequences of repeated incidents, further follow-up as deemed appropriate. This "coaching" discussion is intended to help the practitioner modify their behavior and shall be documented with a copy of the written summary retained in the practitioner’s confidential peer review file.

(f) If such unprofessional conduct persists or escalates despite intervention, the Chief Medical Officer, Chief of Staff, or a designee selected by either of them, shall meet with the practitioner to request their presence at the Medical Executive Committee.

Prior to that meeting, the practitioner will be required to meet with the Joint Chiefs Council which shall include the Chief Medical Officer, Chief of Staff, Vice Chief of Staff, Department Chair, Past Chiefs of Staff, Medical Director(s) of Quality & Safety, to discuss the behavior, the seriousness of its effect on a safe culture, and potential implications in terms of the need for development of a more assertive rehabilitative strategy and/or formal action to address the unprofessional conduct ("counseling" conversation). The Joint Chiefs Council
will make a formal recommendation for the Medical Executive Committee to consider regarding potential corrective/disciplinary action which may include:

(1) Participation in professional counseling or therapy
(2) Mandatory monitoring/proctoring
(3) Referral to the Medical Staff Physician Health Committee
(4) Development of a signed "behavioral contract"
(5) Mandatory leave of absence on a time-limited basis
(6) Restriction, revocation or suspension of clinical privileges on a time limited basis
(7) Restriction, revocation or suspension of hospital membership

The Medical Executive Committee will meet with the practitioner to review the complaint and afford them an opportunity to respond. Upon conclusion of the discussion, a vote will be taken on the formal recommendation (this is a STAT intervention in the Just Culture Algorithm). Restriction, revocation or suspension of Medical Staff clinical privileges and/or membership, or any other remedy allowed under the Medical Staff Bylaws may result if the unprofessional conduct continues, subject to due process as delineated in Article XI of the Medical Staff Bylaws.

This procedure is not necessarily linear, rather will be based on the gravity of the behavior wherein more egregious matters may be escalated, i.e., potential sexual harassment, to be addressed at the Department or Medical Executive Committee level bypassing the cup-of-coffee intervention. (Also see General Guidelines #2)

**PEER REVIEW/CONFIDENTIALITY**

The initial review, as well as any further department/section, or subsequent review by other hospital peer review processes shall be conducted as a confidential peer review in accordance with Mercy Health Muskegon Medical Staff Bylaws.

The complaints investigation procedure is intended to be a confidential procedure. All parties to the process are expected to respect and maintain the confidentiality of the process and not to divulge the details of the investigation to anyone. Where there is any risk to other physicians, employees and patients, disclosure will be made to the extent necessary to offer adequate protection.
Promoting Professionalism Pyramid


- Vast majority of professionals - no issues - provide feedback on progress
- Single "unprofessional" incidents (merit?)
- Apparent pattern
- Pattern persists
- No Δ

Levle 1 "Awareness" Intervention
- "Informal" Cup of Coffee Intervention
- Mandated

Level 2 "Guided" Intervention by Authority
- Mandated Reviews

Level 3 "Disciplinary" Intervention

Just Culture & Code of Conduct Policy Crosswalk

- STAT Counseling Model
- Joint Chiefs Council
- Medical Executive Committee
- START Coaching Model
- Department Peer Review Committees
- Informal "cup-of-coffee" collegial discussion.

Attachment: DOCUMENTATION OF UNPROFESSIONAL/DISRUPTIVE CONDUCT FORM

References:
- Trinity Health Just Culture Learning Curricula, Physician Rx for Just Culture Course designed for Physician Leadership
- The Just Culture Physician Algorithm v1.1
- Center for Patient and Professional Advocacy, Vanderbilt University Medical Center 2012, Promoting Professional Accountability Guidebook for Managing Disruptive Physician Behavior, College of Physicians and Surgeons of Ontario
- Academic Medicine, Vol. 87, No. 7, July 2012, Perspective: A Culture of Respect, Part 2: Creating a Culture of Respect

Review & Approval: Medical Executive Committee, January 13, 2009
Review & Approval: Board Quality Committee, January 20, 2009
Review & Approval: Board of Trustees, January 23, 2009
Biennial Review & Approval: Medical Executive Committee, April 10, 2012
Biennial Review & Approval: Board of Trustees, April 26, 2012
Biennial Review & Approval: Medical Executive Committee, April 8, 2014
Biennial Review & Approval: Board of Trustees, April 24, 2014
Review & Approval: Medical Executive Committee, May 12, 2015
Review & Approval: Board of Trustees, May 28, 2015
Biennial Review & Approval: Medical Executive Committee, April 12, 2016
Biennial Review & Approval: Board of Trustees, April --, 2016
MEDICAL STAFF CODE OF CONDUCT (MS-102)

CONFIDENTIAL - PEER REVIEW

DOCUMENTATION OF UNPROFESSIONAL/DISRUPTIVE CONDUCT FORM

Incident Date ________  Time ________  Location ________________________________

Patient Name (If Applicable) ________________  Witnesses __________________________

Give Brief Description of Incident: ________________________________________________

________________________________________________________

Circumstance(s) which precipitated the incident (e.g., equipment, communication, service availability)

_____________________________________________________________________________

Consequences, if any, of the behavior as it relates to patient care, personnel or Hospital operations:

_____________________________________________________________________________

_____________________________________________________________________________

Name/Title of Person Submitting Report: _____________________  Date ______________

INVESTIGATION PROCESS:

☐ Investigated, no further action warranted  ☐ Collegial Intervention  ☐ Formal Intervention

Summary of Intervenional Action:

Date ___________  Time ___________  Location ________________________________

Action Taken: ________________________________________________________________

_____________________________________________________________________________

Participants: _________________________________________________________________

Signature(s): ________________________________________________________________