ANNA JAQUES HOSPITAL
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL

Medical Staff Code of Conduct	**Administrative**
Subject: Code of Conduct Policy	Policy Number: M-20.2
Category: Medical Staff	**Effective Date: 8/01**
Page 1 of 4	**Revised Dates: 3/10**
Attachments: Disruptive Conduct Report (10/07)	**Review Dates: 12/04; 10/07; 03/10; 9/13**
References:	

POLICY STATEMENT

1. It is the policy of this hospital that all individuals within its facilities be treated with courtesy, respect and dignity. The Board of Trustees of Anna Jaques Hospital requires that all employees, physicians and other independent practitioners (Associate Clinical Staff and Allied Health Professionals) conduct themselves in a professional and cooperative manner in order to promote quality care to patients and a safe working environment. This policy is intended to address conduct which does not meet that standard. In dealing with incidents of inappropriate behavior, the protection of patients, employees, physicians and others in the Hospital and the orderly operation of the Hospital are of paramount concern.

2. Issues of employee conduct will be dealt with in accordance with the Hospital's Human Resource Policies.

3. Conduct that may constitute sexual harassment shall be addressed pursuant to the Hospital's Sexual Harassment Policy.

4. In the event of any conflict between this policy and the bylaws, rules and regulations, or other policies of the Hospital or medical staff, the provisions of this policy shall control.

5. This policy outlines collegial steps (i.e. 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 continuation of conduct that is so unacceptable as to make collegial steps inappropriate at which point immediate disciplinary action is required. Therefore, nothing in this policy precludes immediate referral to the Medical Executive Committee or Board of Trustees or the elimination of any particular step in this policy in dealing with inappropriate conduct.

RESPONSIBILITY: Every healthcare provider, employee, patient or visitor is encouraged to report potentially or perceived disruptive behavior.

PROCESS:

I. IDENTIFICATION OF DISRUPTIVE CONDUCT

A. When a practitioner's conduct disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for Hospital employees or other physicians on the medical staff, or begins to interfere with the practitioner's own ability to practice competently, action must be taken. Sometimes a practitioner's conduct is so disruptive to the operation of the hospital; the value of the one's clinical work is outweighed by the negative impact of his or her behavior. Therefore, steps to identify and address any disruptive behavior must be taken.

II. DISRUPTIVE CONDUCT: Disruptive conduct includes, but is not limited to:

A. Threatening or abusive language directed at nurses, hospital personnel or other physicians (e.g., belittling, berating, implying stupidity and/or threatening another individual).

B. Degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel or the hospital.

C. Profanity or similarly offensive language while in the hospital and/or while speaking with nurses or hospital personnel.

D. Inappropriate physical contact with another individual that is threatening, intimidating or demeaning.

E. Public derogatory comments about the quality of care being provided by other physicians, nursing personnel or the Hospital.

F. Impertinent or inappropriate comments or illustrations written in patient medical records.

G. Refusal to accept medical staff assignments, including repeated failure to respond when on-call, or participate in committee or departmental affairs on anything but his or her own terms, or to do so in a disruptive manner.

H. Impose idiosyncratic requirements on the nursing staff which have nothing to do with better patient care, but serve only to burden the nurses.

III. REPORTING OF DISRUPTIVE CONDUCT:

A. Nurses or other hospital employees who observe, or are subjected to inappropriate conduct by a practitioner shall notify their director or nursing supervisor in the director's absence about the incident. The director will then notify the Vice President, Chief Medical Officer or President/CEO of the Hospital.

B. Upon learning of the occurrence of an incident or inappropriate conduct, the director, Vice President, President/CEO or Chief Medical Officer shall request that the individual who reported the incident document it in writing. The director, Vice President, President/CEO or Chief Medical Officer may also or as an alternative document the incident as reported.

C. The documentation shall include (See Disruptive Conduct Report attached):

1. Identification of the practitioner
2. Date and time of the incident
3. Description of the questionable behavior limited to factual and objective language as much as possible

4. Name of any patient or patient's family member who was involved in the incident, including any patient or family member who witnessed the incident
5. Circumstances which precipitated the incident
6. Consequences, if any, of the behavior as it related to patient care, personnel, or hospital operations
7. Any action taken to intervene in, or remedy, the incident

D. The director shall forward a report to the Chief Medical Officer and President/CEO who shall immediately notify the President of the Medical Staff of the incident.

IV. INVESTIGATION:

A. Once received, a report will be investigated by the Chief Medical Officer, President/CEO and/or President of the Medical Staff beginning with a review of the report. The person who submitted the report and/or witnesses to the incident may also be interviewed to ascertain the details of the incident.

B. The name of the person filing the complaint will not be disclosed to the alleged disruptive physician

C. Upon conclusion of the investigation, the following should be determined:

1. The report is not founded or the conduct is not of a nature which is disruptive within the context of this policy.
2. If determined that the behavior is largely a matter of clinical competence or if patient care is potentially compromised, the matter will be referred to the Chief of the Department of the affected practitioner for further investigation.
3. If determined that the disruptive conduct has occurred and is precipitated by chemical dependency, mental illness or other impairment, the matter will be referred to the Physician Health Committee.
4. If determined that the disruptive behavior has occurred, informal action may be taken (see below).
5. The individual initiating the report will be notified that the matter has been investigated and that appropriate action has been taken.

V. INFORMAL ACTION:

A. In those instances where disruptive behavior is determined to have occurred, the following actions may be taken:

1. After a determination that an incident of disruptive conduct has occurred, the President/CEO and/or Chief Medical Officer or President of the Medical Staff or Chief of Department shall meet with the practitioner. This initial meeting shall be collegial, with the goal of being helpful to the practitioner and with the understanding that certain conduct is inappropriate and unacceptable. During the meeting, the practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide his/her response. The practitioner shall be advised that, if the incident occurred as reported, his/her behavior was not consistent with the standards of the Hospital. Sources of support or counseling can also be offered. The practitioner shall be advised that a prepared copy of the summary of the meeting will

be sent to him/her. A copy will also be put in his/her peer protected file in the Medical Staff Office.

2. If another report of disruptive conduct is received, a second meeting will be held. At least two (2) Medical Staff leaders along with the Chief Medical Officer and President/CEO will be present. At that meeting, the practitioner shall be informed of the nature of the incident and be advised that such conduct is unacceptable. He/she shall also be advised that if there are future complaints about disruptive behavior, the matter will be referred to the Medical Executive Committee and/or Board of Trustees for more formal action. A copy of a letter shall be sent to the practitioner confirming the substance of the meeting. A copy will also be put in the practitioner's peer protected file in the Medical Staff Office.
3. A single additional incident shall result in a formal investigation pursuant to the Medical Staff Bylaws. Exclusion from the Hospital facilities may be appropriate pending the process.
4. The Medical Executive Committee shall be fully apprised of the previous warnings issued to the practitioner and the actions taken to address the concerns. The Medical Executive Committee will refer the matter to the Board of Trustees. Further action shall then be conducted under the direction of the Board of Trustees.
5. If the practitioner continues to engage in inappropriate conduct, the practitioner may be excluded from the Hospital's facilities pending the formal investigation process pursuant to the Medical Staff Bylaws and any related hearing and appeal that may result. Such exclusion is not a suspension of clinical privileges, even though the effect is the same. Rather, the action is taken to protect patients, employees, physicians, and others on the Hospital's premises from inappropriate conduct and to emphasize to the practitioner the most serious nature of the problem created by such conduct. Before any such exclusion, the practitioner shall be notified of the event or events precipitating the exclusion and shall be given an opportunity to respond in writing and to demonstrate that acceptable standards of conduct have not been violated. However, to ensure that there is no inappropriate delay in addressing the concerns, the practitioner must submit any response within three (3) days of being notified.
6. In order to effectively carry out this policy, and as otherwise may be determined by the President/CEO and President of the Medical Staff, the practitioner has no right to have counsel attend any of the meetings described above.

VI. BOARD OF TRUSTEES REPORTING:

A. Significant issues related to physician conduct will be reported to the Board of Trustees.

Authorizing Signatures	Name / Title	Date
Administration: SIGNED ORIGINAL IN ADMINISTRATION	Delia O'Connor President & President/CEO	
Board of Trustees:	David LaFlamme Chairman, Board of Trustees	
Medical Staff Exec:	Saira Naseer, M.D. President, Medical Staff	