**INDU & RAJ SOIN MEDICAL CENTER**

**CODE OF CONDUCT - MEDICAL STAFF**

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**PURPOSE:** Practitioners acknowledge that Soin Medical Center is a faith-based organization. It is the desired culture of the Medical Staff that all Practitioners conduct themselves in a professional manner, since the behavior of any of us reflects on all of us. This Policy outlines minimal expected behaviors for Practitioners and outlines consequences that precede the processes contained in the Medical Staff Bylaws.

Note: For purposes of this Policy only, the term "Practitioner" includes Allied Health Professionals.

**POLICY:**

1. The objective of this Policy is to ensure optimum patient care by promoting a safe, cooperative, and professional healthcare environment, and to prevent or eliminate conduct that:

   a) Disrupts the operation of the Hospital or impugns the care provided at the Hospital.

   b) Negatively affects the ability of others to perform their jobs.

   c) Creates a hostile work environment for Hospital employees or other Practitioners.

   d) Interferes with an individual's ability to practice competently.

   e) Adversely affects or impacts the community's confidence in the Hospital and/or Medical Staff's ability to provide quality patient care.

2. All Practitioners, regardless of status or tenure, will be held to the same standards. 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 corrective action process as outlined in the Medical Staff governing documents.

3. It is the express intent of the Medical Staff that all Practitioners shall abide by applicable laws and regulations of government agencies, applicable standards of accrediting organizations, Corporate Compliance policies, Hospital and Medical Staff Bylaws, Manuals, and other applicable policies. These include but are not limited to behaviors concerning sexual harassment, discrimination or harassment based upon any legally

protected characteristic including race, color, religion, national origin, sex, sexual orientation, pregnancy, age, disability or military status, chemical abuse, the Health Insurance Portability & Accountability Act ("HIPAA"), and the Emergency Medical Treatment & Active Labor Act ("EMTALA") that have specific and comprehensive actions delineated for verified transgressions involving these behaviors and which will not be further addressed in this Policy.

4. In dealing with all incidents of inappropriate conduct, the protection of patients, employees, Practitioners, 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 harassment are also critical. This Policy will delineate collegial and educational efforts that may be used by Medical Staff leaders to address undesirable behaviors prior to invoking procedural due process or otherwise taking appropriate action as described in the Bylaws. These steps may include counseling, warnings, and meeting with the Practitioner to discuss conduct in question.

5. All efforts undertaken under this Policy are part of the Hospital's performance improvement, professional, and peer review activities. As such, they are non-discoverable peer review protected documents/activities and will be protected vigorously by the Hospital.

## EXAMPLES OF DISRUPTIVE CONDUCT:

Disruptive conduct is defined as personal conduct, verbal or physical, that adversely affects the deliverance of safe, competent, and dignified patient care. The Medical Staff realizes that, in some cases, disruptive conduct is in the eye of the beholder. Most of the time, disruptive behavior is easy to identify. Examples of disruptive conduct include, but are not limited to:

1. Threatening or abusive language directed at patients, nurses, Hospital personnel, or Practitioners (*e.g.*, belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies incompetence).

2. Degrading or demeaning comments regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital.

3. Intentional or gratuitous profanity or similarly offensive language while in the Hospital and/or while speaking with Practitioners, nurses, or other Hospital personnel.

4. Lack of appropriate response to emergency or night call including, where appropriate, one (1) office visit follow up without regard to insurance status.

5. Inappropriate physical contact with another individual that is threatening or intimidating.

6. Derogatory comments directed specifically to patients or otherwise in a public forum about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff and/or administrative channels.

7. Inappropriate medical record entries impugning the quality of care being provided by the Hospital, Practitioners, or any other individual.

8. Imposing onerous requirements on the nursing staff or other Hospital employees that are beyond their stated job description.

9. Refusal to abide by Medical Staff requirements as delineated in the Medical Staff governing documents as interpreted by duly elected Medical Staff representatives.

10. Refusal to participate in Medical Staff governance in such a way that disrupts function under the current Medical Staff Bylaws. That is to say, refusal to accept assignment or participate in committee, Clinical Service, or peer review affairs except on one's own terms (providing there is no perceived conflict of interest), or disrupting the orderly conduct of Clinical Service and other committees and Medical Staff meetings.

11. Theft, destruction of property.

12. Falsification or destruction of a medical record.

13. Repetitive or persistent failure to complete medical records despite administrative notices, warnings and/or automatic Medical Staff suspension for failure to complete medical records.

14. Failure to present oneself with professional dress or demeanor in dealing with patients, family members, and other healthcare workers.

15. Other particular behaviors not elucidated but deemed inappropriate by a simple majority of the Medical Executive Committee;

**IDENTIFICATION AND INTERVENTIONS FOR DISRUPTIVE CONDUCT:**

1. The steps outlined in this section are intended as collegial interventions that precede the processes outlined by the Medical Staff Bylaws and any requirements that have the potential of resulting in reporting to the National Practitioner Data Bank or Ohio State Medical Board. Should the Practitioner feel the need to have legal counsel present at any of these steps, s/he may arrange representation at personal expense and in a timely fashion so as not to delay this process.

2. Any Practitioner, employee, patient, or visitor may report incidents of disruptive behavior. Practitioners and Hospital employees are encouraged to report such behaviors to their supervisor or to the Chief of Staff so that behavioral counseling may occur before such behavior disrupts patient care.

3. Once received, a report will be investigated by the Vice President Medical Affairs ("VPMA") and/or the Chief of Staff with or without the assistance of the appropriate Clinical Service Chief. They shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident. Unfounded reports may be dismissed. Those reports considered verifiable will be addressed as follows:

    a) After a determination that an incident of inappropriate conduct has occurred, the VPMA and/or the Chief of Staff and/or their respective designee(s) shall meet with the Practitioner. This initial meeting shall be collegial, with the goal of being helpful to the Practitioner in 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 concerning the incident. The Practitioner shall also be advised that, if the incident occurred as reported, his/her conduct was inconsistent with the culture and standards of the Medical Staff. To prevent unintended retaliatory behavior, the identity of the individual preparing the report of inappropriate conduct will not be disclosed at this time. If the VPMA and Chief of Staff agree in advance that it is appropriate to identify personnel involved in the complaint, the Practitioner shall be advised that any retaliation against the person reporting the incident will be grounds for summary suspension and immediate exclusion from all Hospital facilities.

    b) This initial meeting may also be used to educate the Practitioner about administrative channels that are available for registering complaints or concerns about quality or services, if the individual's explanation suggests that such concerns led to the inappropriate behavior. Other sources of support or counseling may also be identified for the Practitioner, as appropriate.

c) The Practitioner shall be advised that a summary of the meeting will be prepared and a copy provided to him/her. The Practitioner may prepare a written response to the summary, both of which shall be kept in the confidential portion of the Practitioner's credentials file. These documents shall be part of professional and peer review activities. As such they are non-discoverable peer review protected documents and will be maintained so as to protect the individuals named therein from unwarranted public scrutiny or legal action.

d) If a second substantiated report of inappropriate conduct involving the Practitioner is received, a second meeting shall be held. It is advisable that at least three (3) people (*e.g.,* the VPMA, Chief of Staff, Clinical Service Chief, other Medical Staff officer, Medical Director of Quality, *etc.*) be present to meet with the Practitioner. At this meeting, the Practitioner shall be informed of the nature of the incident and be advised that such conduct is unacceptable. The Practitioner shall be advised that if there is a future complaint about inappropriate conduct, the matter will be referred to the Medical Executive Committee ("MEC") for more formal investigation and possible action. A letter shall be sent to the Practitioner confirming the substance of the meeting, a copy of which shall be kept in the confidential portion of the Practitioner's credentials file (along with any response submitted). The letter will contain a clarification of the concerns raised, and specific behaviors proscribed *i.e.,* a "personal code of conduct" that amplifies the intent of section (a) above.

e) In the event there is a third substantiated report of inappropriate conduct, the Practitioner shall be given a final written warning that the inappropriate conduct will not be tolerated and that the matter has been referred to the MEC. The letter shall describe the inappropriate conduct, outline the steps that have been taken in the past to correct that conduct, and detail the kind of behavior that is acceptable and unacceptable. The letter may include notice of summary suspension from the Medical Staff and/or Privileges and will define the conditions of reinstatement for reappointment/Privileges (consistent with the Medical Staff Bylaws). The Practitioner shall be required to sign the letter, acknowledging receipt. If the Practitioner refuses to sign the letter, a summary suspension may result and further investigative actions will be according to the Medical Staff governing documents.

f) The MEC shall be fully apprised of the previous warnings issued to the Practitioner and the actions taken to address the concerns. The MEC may take additional steps to address the concerns as delineated in the Medical Staff Bylaws.