Community Health Network, Inc.
MEDICAL STAFF POLICIES & PROCEDURES

☑ **Community Hospital East** ☑ **Community Hospital South**
☑ **Community Hospital North** ☑ **Community Heart and Vascular Hospital**

TITLE: PROFESSIONAL CODE OF CONDUCT

PURPOSE: All Members and Allied Health Professionals (hereinafter referred to in this Policy as "Member(s)") and hospital personnel, including Clinical Assistants, shall treat each other with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner. Improving interactions among Members and hospital personnel through collaboration, communication, and collegiality are essential for the provision of safe and competent patient care.

The purpose of this Policy is to ensure that all allegations concerning inappropriate conduct of a Member are handled confidentially, expeditiously, and within the confines of the hospital's peer review process. This Policy outlines collegial and educational efforts to address inappropriate conduct concerns. The goal of these efforts is to resolve the concern through voluntary, responsive action by the Member whose conduct is at issue and thus avoid the necessity of proceeding to corrective action. In dealing with incidents of inappropriate conduct, the protection of patients, employees, Members and others in the hospital and the orderly operation of the hospital are paramount concerns.

All Members are governed by this Policy. Any Member who is employed by the hospital is also governed by the Human Resource policies and may have additional duties, obligations, and expectations related to conduct as set forth in the respective employment contracts and other personnel policies. This Policy does not prohibit the Board of Directors, the Medical Executive Committee, or those authorized to impose summary suspensions, from taking any action necessary including summarily suspending a Member if warranted. This Policy incorporates the Network Policy concerning Professional Code of Conduct.

I. EXAMPLES OF APPROPRIATE AND INAPPROPRIATE CONDUCT

A. Appropriate Conduct. Expectations of appropriate conduct can be found throughout the Medical Staff Bylaws, Rules and Regulations, and Policies, and the Hospital's and Network's Policies. To summarize, these behaviors include but are not limited to:

- provide quality services;
- continuously improve performance and skills;
- value the safety and rights of the patients and others;
- use the limited resources of the hospital in an efficient manner;
- treat peers, co-workers and patients professionally and courteously;
- handle disagreements with courtesy, respect, civility and dignity for one another; and
- be a good citizen of the hospital.

B. Inappropriate Conduct. To educate Members and for enforcement purposes, examples of "inappropriate conduct" include, but are not limited to:

- threatening, intimidating, or abusive language directed at patients, nurses, hospital personnel, or Members (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies incompetence, threatening to get an employee fired);
- degrading, demeaning or condescending comments or voice intonation regarding patients, families, nurses, physicians, hospital personnel, or the hospital;
- using language while in the hospital and/or while speaking with nurses or other hospital personnel that may be reasonably considered offensive to others or disruptive

to the workplace or patient care;

- inappropriate physical contact with another individual that is threatening or intimidating;
- derogatory comments outside of appropriate medical staff and/or administrative channels about the quality of care provided by the hospital, another Member, or any other individual;
- inappropriate medical record entries impugning the quality of care being provided by the hospital, another Member, or any other individual;
- refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes, reluctance or refusal to answer questions, return phone calls or pages, impatience with questions or imposing onerous requirements on the nursing staff or other hospital employees;
- refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Rules and Regulations, and Policies 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 others;
- 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) innuendos, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds; (b) displaying derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures; (c) unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and (d) making or threatening retaliation as a result of an individual's negative response to harassing conduct; or
- retaliating against the individual raising a concern, any witness to the behavior, or Member serving on the peer review committee addressing the concern.

II. GENERAL PRINCIPLES OF ENFORCEMENT

1. All allegations of inappropriate conduct raised about a Member will be addressed in accordance with this Policy, except for allegations that could reasonably be interpreted as sexual harassment. Any allegation of sexual harassment shall be handled through hospital policies. However, a note referencing such complaint will be maintained in the confidential peer review file of the Member but all documents concerning the sexual harassment complaint investigation will be maintained in a confidential file of the Personnel Committee of the Board of Directors acting in their capacity as a peer review committee.

2. If the allegation involves a hospital employed Member, Administration will determine if the inappropriate conduct will also be addressed by Human Resources. In such circumstances, the results of any investigations and/or disciplinary actions taken by Human Resources will be shared with the appropriate peer review committee and may be used to establish focused performance activities or ongoing performance improvement activities for the Member (if appropriate).

3. Notwithstanding the employment status of a Member, the Medical Executive Committee may ask Human Resources to serve as the "personnel" of the MEC to gather facts on behalf of the MEC by interviewing hospital employees complaining about inappropriate conduct

4. A single incident of inappropriate conduct or a pattern of inappropriate conduct may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral to the MEC of a matter being addressed through this Policy or the elimination of any particular step in the Policy.

5. In order to enforce the objectives of this Policy, and except as otherwise may be determined by the Chief of Staff, the Member's legal counsel shall not attend any of the collegial intervention meetings described in this Policy.

6. The hospital will provide education to all Members regarding appropriate and inappropriate behavior. The hospital will also make employees and other personnel aware of this Policy and shall institute procedures to facilitate prompt reporting of inappropriate conduct and prompt action as appropriate under the circumstances.

III. REPORTING OF INAPPROPRIATE CONDUCT

1. Any individual who observes "inappropriate conduct" by a Member shall notify their supervisor about the incident and make such report as required by this Policy and any other applicable Policy. Any Member who observes such inappropriate conduct shall notify an officer of the Medical Staff and make such report as required by this Policy.

2. The individual who reports an incident of inappropriate conduct shall be requested to document their observations. If the individual does not wish to do so, the supervisor or Medical Staff Officer shall document it, after attempting to ascertain the individual's reasons for declining and encouraging the individual to do so.

3. Documentation should include:
   - (A) the date and time of the event;
   - (B) the name of any staff member, patient affected or patient's family who may have been involved in the incident;
   - (C) the circumstances which precipitated questionable conduct;
   - (D) names of other witnesses, if any;
   - (E) a factual description of the questionable conduct;
   - (F) record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening; and
   - (G) any action taken to intervene in, or remedy, the incident.

4. The documentation shall be delivered to the appropriate peer review committee.

IV. REVIEWING COMPLAINTS OF INAPPROPRIATE CONDUCT

1. The President/Chief of Staff or designee shall review and/or be informed of all allegations of "inappropriate conduct." The Chief of Staff or designee will provide an acknowledgement of the report to the complaining party and will assure appropriate feedback to the reporting individual. Notwithstanding the foregoing, no confidential, privileged information shall be released to any individual outside the peer review process.
2. All reports will be reviewed and even if the report of inappropriate conduct is anonymous. The Chief of Staff will exercise discretion as to whether or not to investigate the matter.
3. The Member will be informed that an allegation has been made. If the allegation warrants a discussion with the Member, the Chief of Staff or his designee shall initiate that discussion as soon as possible. The purpose of the discussion is to obtain the Member's version of the events and inform the Member that he may submit a rebuttal to the allegations in writing. Any concerns or complaints expressed by the Member will be addressed under Section VIII of this Policy. The Chief of Staff or his designee shall confirm the discussion and expectations of the hospital in a letter to the Member. A copy of the letter will be placed in the providers confidential peer review file.
4. If such conduct continues despite this collegial intervention, the Chief of Staff shall bring it to the attention of the Quality Assurance Council of the MEC for further action.
5. If the conduct continues despite MEC involvement, the Chief of Staff will ask the Chairman of the Board of Directors, or his/her designee, to meet with the Member to advise the Member that such conduct is intolerable and must stop. The Chief of Staff or

their designees will also be in attendance. This meeting is not a discussion, but rather, constitutes the Member's final warning. It shall be followed with a letter reiterating the warning.

6. An additional incident(s) may result in initiation of formal disciplinary action pursuant to the Medical Staff Bylaws, Article 5.1. A precautionary suspension may be appropriate pending this process. The MEC shall be fully apprised of the previous warnings issued to the Member and any other trends or ongoing performance information gathered, in order to take whatever action is necessary to terminate the unacceptable conduct.
7. Information gathered concerning allegations of Members shall be reviewed periodically and shall be reviewed and considered by the Credentials Committee prior to making any recommendation for reappointment or entertaining any request for increased privileges.

V. PATIENT CARE CONCERNS

1. Some reports containing allegations of inappropriate conduct present an opportunity for patient care improvement. Such reports shall be directed to the appropriate peer review committee overseeing the ongoing professional performance improvement activities of Members. Concerns raised about a Member's professional practices present an opportunity for improvement through education.
2. The Chief of Staff or his designee shall decide whether the allegation presents an opportunity to improve the quality of services provided by the Member and/or hospital. If so, the allegation shall be directed to the appropriate Department Chief and peer review committee. The Chief of Staff may direct the Physician Executive to gather additional facts. The results of any inquiry shall be reduced to a report and forwarded to the appropriate Department Chief and peer review committee.
3. Unless the Chief of Staff or his designee has already met with the Member, the Department Chief shall be responsible for exploring the concern and opportunity for education with the Member. The Department Chief will provide the Member an opportunity to discuss the practice and make suggestions for improvement. If the concern is about a physician extender, the sponsoring physician shall be in attendance at the meeting.
4. The Department Chief shall present to the Chief of Staff the follow up from the Member.
5. The Chief of Staff with the guidance of the Physician Executive shall authorize the next step in presenting the concern and opportunity for education to the appropriate peer review body for trending, focused reviewed, and/or ongoing professional performance improvement activities.

VI. Well Being, Illness and Impairment Concerns

All allegations concerning the well-being, illness or impairment of a Member will be addressed in accordance with the Practitioner Wellness Policy.

VII. Member Reports of Concerns Relating to Department/Service Area

1. In order to ensure a timely follow-up to concerns/complaints expressed by a Member regarding the level of performance by a department and/or service area, the Member should address the concern at the time of the occurrence with the involved individual when possible, or if needed, with the person in charge of the Department.
2. If the concern remains unresolved and/or becomes a recurring concern and/or is raised at a meeting with the Chief of Staff or his designee or the MEC, the Chief of Staff or his designee shall notify the Physician Executive who will delegate the concern directly to the VP of the responsible department/service area for follow up.
3. The vice president of the responsible department will investigate and provide a written follow-up to the Physician Executive and a proposed written plan of action within

twenty-one (21) days, if any is needed. In conducting the investigation, the VP of the responsible department/service area is acting as the "personnel" of the MEC.

4. The Physician Executive will present the proposed written follow-up and written action plan, if any, to the MEC for action. A copy of the concern, the department's written follow-up and written plan if any, and any input from the MEC will be forwarded to the Quality Improvement Committee for ongoing department/service area performance improvement activities.
5. Unless more time is needed to address the concern, the Chief of Staff or his designee shall notify the complaining Member within thirty (30) days of the proposed written follow-up and action plan, if any. If more time is needed to address the concern, the Chief of Staff or his designee will notify the complaining Member of the status of the review and will notify the complaining Member when the concern has been considered fully addressed.
6. Information concerning allegations about nursing staff and other personnel collected during this process will be forwarded to Human Resources in order that it be reviewed and considered by the employee's supervisor prior to annual evaluations.

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