St. David's South Austin Medical Center

Practitioner Professionalism Policy

MEC 5/10/2019
BOT 5/16/19
(Replaces Professional Conduct Policy)

TABLE OF CONTENTS

PAGE

MEDICAL STAFF
PROFESSIONALISM POLICY

1. POLICY STATEMENT

1.A *Policy Objectives.*

(1) This Policy incorporates the HCA Code of Conduct. It outlines progressive steps, beginning with collegial and educational efforts, which can be used by Medical Staff and Hospital leaders to address conduct that does not meet expected standards. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve the concerns that have been raised in a constructive manner, and thus avoid the necessity of proceeding through the disciplinary process outlined in the Medical Staff Credentials Policy.

(2) This Policy is not intended to interfere with a Practitioner's ability to express, in a professional manner and in an appropriate forum:

(a) opinions on any topic that are contrary to opinions held by other Practitioners, Medical Staff Leaders, or Hospital personnel;

(b) disagreement with any Medical Staff or Hospital Bylaws, policies, procedures, proposals, or decisions; or

(c) constructive criticism of the care provided by any Practitioner, nurse, or other Hospital personnel.

1.B *Scope of Policy.*

(1) This Policy applies to all Practitioners (as defined in Section 1.D) who provide patient care services at the Hospital.

(2) If the Practitioner involved is also employed by the Hospital or a Hospital-related entity (the "employing entity"), Medical Staff Leaders and appropriate representatives of the employing entity will determine which process will be used for the review.

(a) If the matter will be reviewed using the Medical Staff process as set forth in this Policy, a representative of the employing entity will be invited to attend relevant portions of committee meetings involving the Practitioner, as well as participate in any interventions that may be necessary following the review. Actual documentation from the Medical Staff process will not be disclosed to the employing entity for inclusion in the employment file, but the employing entity will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities in accordance with HCA policies related to information sharing between HCA entities.

(b) If the matter will be reviewed by the employing entity pursuant to its policies:

(i) the Medical Staff process shall be held in abeyance and the Medical Executive Committee notified;

(ii) the PPE Support Staff will assist the employing entity with witness interviews, document review, data compilation, and similar fact-finding. Documentation of such fact-finding will be maintained in the Practitioner's confidential Medical Staff peer review/quality file consistent with the state peer review statute, but the employing entity will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities;

(iii) the Medical Executive Committee will be kept informed of the progress and outcome of the review by the employing entity; and

(iv) the Medical Executive Committee may choose, at any time and in its sole discretion, that the matter shall also be reviewed pursuant to this Policy. However, neither such a review by the Medical Executive Committee nor any other provision of this Policy shall be interpreted to affect the right of the employing entity to take any action authorized by the employment contract with the Practitioner.

(3) If a matter involves both clinical and behavioral concerns, the Chairs of the Medical Executive Committee and the Professional Practice Evaluation Committee ("PPEC") shall coordinate the reviews. The behavioral concerns may either be:

(a) addressed by the Medical Executive Committee pursuant to this Policy, with a report to the PPEC; or

(b) addressed by the PPEC as part of its review under the Professional Practice Evaluation Policy, using the provisions in this Policy for guidance.

(4) All efforts undertaken pursuant to this Policy are part of the Hospital's performance improvement and professional practice evaluation/peer review activities.

(5) A flow chart depicting the review process for concerns regarding professional conduct pursuant to this Policy is attached as **Appendix A**.

1.C ***Expectations for Professional Conduct/Culture of Safety.*** Communication, collegiality, and collaboration are essential for the provision of safe and competent patient care. As such, all Practitioners must abide at all times with HCA's Code of Conduct and this Policy

and treat others with respect, courtesy, and dignity, and conduct themselves in a professional and cooperative manner.

In dealing with incidents of inappropriate conduct, the following are paramount considerations:

(1) the protection of patients, employees, Practitioners, and others and the orderly operation of the Medical Staff and Hospital;

(2) compliance with the law and providing an environment free from harassment and other forms of discrimination; and

(3) assisting Practitioners in resolving conduct issues in a constructive, educational, and successful manner.

1.D ***Definitions.***

(1) "Medical Staff Leader" means any Medical Staff Officer, Department Chairperson, Division Director, or committee chairperson.

(2) "Practitioner" means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Advanced Practice Professionals.

(3) "PPE Support Staff" means the clinical and non-clinical staff who support the professional practice evaluation ("PPE") process generally and the review of issues related to professionalism described in this Policy. This may include, but is not limited to, staff from the Quality Department and/or Medical Staff Services department

2. EXAMPLES OF INAPPROPRIATE CONDUCT. To aid in both the education of Practitioners and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

(a) abusive or threatening language directed at patients, nurses, students, volunteers or other visitors, other Hospital personnel, or Practitioners (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);

(b) degrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital;

(c) refusal or failure to answer questions, or return phone calls or pages in a timely manner as defined in the Medical Staff Bylaws documents or other applicable policies;

(d) offensive language (which may include profanity or similar language) while in the Hospital and/or while speaking with patients, nurses, or other Hospital personnel;

(e) retaliating against any individual who may have reported a quality and/or behavior concern about a Practitioner, provided information related to such a matter, or otherwise been involved in the professional practice evaluation/peer review process in any way (this means a Practitioner may not, under any circumstances, discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual);

(f) inappropriate physical contact with another individual or other aggressive behavior that is threatening or intimidating;

(g) throwing an object of any kind, including but not limited to any medical/surgical instrument or supply;

(h) repeatedly failing to renew legally-required credentials prior to expiration;

(i) derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff and/or Hospital administrative channels;

(j) inappropriate medical record entries impugning the quality of care being provided by the Hospital, Practitioners, or any other individual, or criticizing the Hospital or the Hospital's policies or processes, or accreditation and regulatory requirements;

(k) imposing idiosyncratic requirements on Hospital staff that have no impact on improved patient care, but serve only to burden the Hospital or Hospital employees with "special" techniques and procedures;

(l) altering or falsifying any medical record entry or hospital document (including, but not limited to, incorrectly dating or timing an entry or document to give the impression it was completed prior to when it was actually completed);

(m) completing medical record entries based on a template without considering the care actually provided to the patient, or using the "copy and paste" or "pull forward" functions of the medical record to populate fields without verifying that the information is accurate for the patient in question;

(n) refusal or failure to use or use properly documentation technology (e.g., CPOE, EHR, and other approved technology);

(o) inappropriate access, use, disclosure, or release of confidential patient information;

(p) audio, video, or digital recording that is not consented to by others present, including patients and other members of the care team;

(q) use of social media in a manner that involves inappropriate conduct as defined in this Policy or other Medical Staff or Hospital policies;

(r) disruption of hospital operations, hospital or medical staff committees or departmental affairs;

(s) treating self or family members, or treating any individual (including colleagues or coworkers) without first performing an appropriate assessment and creating a proper medical record;

(t) diverting or otherwise misappropriating drugs (e.g., for the Practitioner's own use, to supply a family member or friend, or to sell). Practitioners who divert drugs for their own use may be referred for review under the Practitioner Health Policy as set forth in Section 6.H;

(u) intentional misrepresentation to Hospital administration, Medical Staff Leaders, other Practitioners, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken;

(v) disregard of or refusal to abide by Medical Staff requirements as delineated in the HCA Code of Conduct, the Medical Staff Bylaws, Credentials Policy, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call issues, response times, medical recordkeeping, other patient care responsibilities, failure to participate on assigned committees, failure to cooperate with utilization oversight activities, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and Hospital employees); and/or

(w) engaging in identity-based harassment as described in Section 8 of this Policy.

3. GENERAL GUIDELINES/PRINCIPLES

3.A ***Immediate Referrals to Medical Executive Committee.*** This Policy outlines collegial and progressive steps (e.g., counseling, warnings, meetings, and behavior modification education) that can be taken to address concerns about inappropriate conduct by Practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Medical Executive Committee or the elimination of any particular step in the Policy.

3.B ***Coordination with Other Policies That Govern Professional Conduct.*** If a report of inappropriate behavior involves an issue that is also governed by another Hospital policy that governs professional conduct (including, but not limited to, alleged violations of the Hospital's HIPAA or corporate compliance policies by a Practitioner), the Chief of the Medical Staff and the PPE Support Staff *or the CMO* will notify the person or committee responsible for that other policy of the substance of the report. Efforts will be made to coordinate the review that occurs under this Policy with the review under such other policy. For example, individuals responsible for such other policies (such as the Hospital's HIPAA Privacy Officer or Corporate Compliance Officer) may be invited to take part in the witness interviews described in this Policy or may discuss the matter with the Medical Executive Committee or its representatives.

3.C ***No Legal Counsel or Recordings During Collegial Meetings.*** In order to promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner whose conduct is at issue shall involve only the Practitioner and the appropriate Medical Staff and Hospital leaders (unless the Medical Staff or Hospital leaders determine otherwise in a particular situation). No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings, and no recording (audio or video) shall be permitted or made.

3.D ***Education Regarding Appropriate Professional Behavior.*** Medical Staff and Hospital leaders shall educate all Practitioners regarding appropriate professional behavior, make employees and other personnel aware of this Policy, and shall encourage the prompt reporting of inappropriate conduct.

3.E ***Delegation of Functions.*** When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.

4. REPORTING OF INAPPROPRIATE CONDUCT AND INITIAL REVIEW

4.A ***Reports of Inappropriate Conduct.*** Any Hospital employee or Practitioner who observes, or is subjected to, inappropriate conduct by a Practitioner shall report the incident in a timely manner by submitting a completed Professional Conduct Reporting Form to the PPE Support Staff (see **Appendix B**) or through some other approved Hospital reporting mechanism. The PPE Support Staff shall log the referral into a confidential peer review database.

4.B ***Conduct of a Criminal Nature.*** Anyone who observes or receives a credible report about a Practitioner's conduct that may be of a criminal nature (e.g., misappropriation of drugs, theft, assault, abuse of patient, fraudulent billing) shall report it directly through one's supervisor or chair to the Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer *or Chief Medical Officer* **[if applicable]**. If the officer ascertains that the conduct may be of a criminal nature, the Hospital's assigned Operations Counsel and appropriate law enforcement personnel should be notified in addition to pursuing the further steps in this Policy or other applicable policies.

4.C ***Follow-up with Individual Who Filed Report.*** The PPE Support Staff *and/or the Chief Medical Officer* **[if applicable]** shall follow up with individuals who file a report by:

(1) thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care;

(2) informing them that the matter will be reviewed in accordance with this Policy and that they may be contacted for additional information;

(3) informing them that no retaliation is permitted against any individual who raises a concern and to report any retaliation or any other incidents of inappropriate conduct; and

(4) informing them that, due to confidentiality requirements under state law, no further information can be provided regarding the outcome of the review.

A letter that can be used for this purpose is attached as **Appendix C**. As an alternative to sending a letter, the content of the letter may be used as talking points to discuss verbally with the individual who reported a concern regarding conduct.

4.D ***Preliminary Notification to Practitioner.*** The Chief of the Medical Staff or *Chief Medical Officer* shall notify the Practitioner that a concern has been raised and the matter is being reviewed. Generally, this preliminary communication should occur via a telephone call or a personal discussion as soon as practical. The Practitioner will be notified that he or she will be invited to provide input regarding the matter if the facts underlying the incident are determined to be credible, but that he or she is also free to submit input at any time. The Practitioner will also be reminded to avoid any action that could be perceived as retaliation (including any attempt to discuss the matter with an individual who the Practitioner may believe raised the concern or provided information about it.) Instructions and a form that may be used to help prepare for and document the preliminary notification described in this section are attached as **Appendix D**.

4.E ***Fact-Finding to Determine if Report Is Credible.*** The PPE Support Staff, human resources personnel, other administrative personnel, the *Chief Medical Officer*, and/or Chief of the Medical Staff shall interview witnesses or others who were involved in the incident, and gather any other necessary documentation or information (e.g., interviews with core leaders or nurse/area leaders) needed to assess the credibility of the report. **Appendix E** contains a script that may be used for interviews, along with sample interview questions.

(1) ***Report <u>Not Credible</u>.*** If the *Chief Medical Officer* and Chief of the Medical Staff determine that a report is not credible, the matter shall be closed and the Practitioner will be notified of this determination. The Medical Executive Committee will also be notified, to allow it to conduct oversight and monitor the process for consistency. The individual who filed the report may be notified that the report was not substantiated, at the discretion of the Medical Executive Committee. Intentionally false reports will be grounds for disciplinary action. False reports by Practitioners will be referred to the Medical Executive Committee , while false reports by Hospital employees will be referred to human resources.

(2) ***Report Determined to Be <u>Credible</u>.*** If the *Chief Medical Officer* and Chief of the Medical Staff determine that a report is credible, input will be obtained from the Practitioner as set forth in Section 5. The PPE Support Staff shall then prepare a summary report of the matter for review by the Medical Executive Committee .

5. OBTAINING INPUT FROM THE PRACTITIONER

5.A ***General.*** For reports that are determined to be credible, the Chief of the Medical Staff, *Chief Medical Officer*, and/or PPE Support Staff will provide details of the concern to the Practitioner and ask the Practitioner to provide a written explanation of what occurred and his or her perspective on the incident.

5.B ***Identity of Reporter.*** The specific identity of the individual reporting the inappropriate conduct or otherwise providing information about a matter will not be disclosed to the Practitioner unless:

(1) the individual specifically consents to the disclosure;

(2) the Medical Executive Committee determines that an exception must be made in a particular situation to ensure an appropriate review, in which case the individual in question will be notified; or

(3) information provided by the individual is used to support an adverse professional review action that results in a Medical Staff hearing.

5.C ***Confidentiality.*** The Practitioner must maintain all information related to the review in a strictly confidential manner, as required by Texas law. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the written permission of the , except for any legal counsel who may be advising the Practitioner.

5.D ***Retaliation.*** The Practitioner may not retaliate against anyone who he or she believes may have raised a concern, provided information regarding the matter, or otherwise been involved in the review process. This means a Practitioner may not, under any circumstances, discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual. If a Practitioner wishes to offer an apology to any individual, the Practitioner must contact the Medical Executive Committee and comply with its requirements regarding the manner in which the apology is provided.

5.E ***Reminder of Practitioner's Obligations.*** The PPE Support Staff, *Chief Medical Officer* or Chief of the Medical Staff will remind the Practitioner of the obligations set forth in this section as part of seeking his or her input. A cover letter similar to the one set forth in **Appendix F** shall be used for this purpose. The Practitioner may also be asked to sign the "Confidentiality and Non-Retaliation Agreement" that is attached as **Appendix G** before such a letter is sent if there are particular concerns about maintaining confidentiality or ensuring a professional, non-threatening environment for the individuals involved in a specific situation.

6. MEDICAL EXECUTIVE COMMITTEE (MEC) PROCEDURE

6.A ***Initial Review.*** The Medical Executive Committee shall review the summary prepared by the PPE Support Staff and all supporting documentation, including the response from the Practitioner. If necessary, the MEC may also meet with the individual who submitted the report and/or any witnesses to the incident. If it determines that it would be necessary or helpful in addressing the reported concern, the MEC may also consult with or include the appropriate Department Chairperson in the review or may appoint an ad hoc committee to review the incident and report back to it.

6.B ***Meeting Between Practitioner and MEC.*** A meeting may be held between the Practitioner and the MEC to discuss the circumstances further if either the MEC or the Practitioner believes that such a meeting would be helpful prior to the MEC concluding its review and making a determination. The MEC may also obtain additional written input from the Practitioner using the process set forth in Article 5.

6.C ***Medical*** Executive Committee***'s Determination and/or Intervention.*** Based on all of the information received, the Medical Executive Committee may:

(1) determine that no further review or action is required;

(2) send the Practitioner a letter of guidance or counsel about the conduct;

(3) engage in face-to-face collegial intervention, education, and coaching efforts with the Practitioner, including, when appropriate, education about administrative channels that are available for registering concerns about quality or services, if the Practitioner's conduct suggests that such concerns led to the behavior. Other sources of support may also be identified for the Practitioner, if appropriate;

(4) develop a Performance Improvement Plan for Conduct, as described in Section 6.D below; or

(5) refer the matter to the Medical Executive Committee.

The Medical Executive Committee shall also inform the relevant Department Chairperson of its determination and intervention.

6.D ***Performance Improvement Plan for Conduct.*** A Performance Improvement Plan for Conduct may include, but is not limited to, one or more of the actions in this Section. None of these actions entitles the Practitioner to a hearing or appeal as described in the Medical Staff Credentials Policy, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank. (**Appendix H** provides additional guidance regarding these and other Performance Improvement Plan options for conduct and their related implementation issues.)

(1) ***Meeting with Medical Executive Committee or Designated Group.*** The Practitioner may be required to meet with the Medical Executive Committee or a designated group (including the PPEC, another Medical Staff committee, or an ad hoc group) to discuss the concerns with the Practitioner's conduct and the need to modify the conduct. An ad hoc group may include any combination of current

or past Medical Staff Leaders, Hospital leaders, outside consultants, and/or the Board Chair or other Board members if the Medical Executive Committee determines that Board member involvement is reasonably likely to impress upon the Practitioner involved the seriousness of the matter and the necessity for the Practitioner's conduct to improve. A letter outlining the discussion and expectations for conduct shall be sent to the Practitioner after the meeting;

(2) ***Periodic Meetings with Medical Staff Leaders or Mentors.*** The Practitioner may be required to meet periodically with one or more Medical Staff Leaders or a mentor designated by the Medical Executive Committee . The purpose of these meetings is to provide input and updates on the Practitioner's performance, as well as to offer assistance and support with any challenging issues the Practitioner may be encountering.

(3) ***Letter of Warning or Reprimand.*** The Medical Executive Committee may send the Practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing;

(4) ***Review of Literature Concerning the Connection Between Behavior and Patient Safety.*** The Medical Executive Committee may require the Practitioner to review selected literature concerning the established connection between behavior and patient care and safety and then provide a report to the Medical Executive Committee summarizing the information reviewed and how it can be applied to the individual's practice.

(5) ***Behavior Modification Course.*** The Medical Executive Committee may require the Practitioner to complete a behavior modification course that is acceptable to the Medical Executive Committee and/or

(6) ***Personal Code of Conduct.*** The Medical Executive Committee may develop a "personal" code of conduct for the Practitioner, make continued appointment and clinical privileges contingent on the Practitioner's adherence to it, and outline the specific consequences of the Practitioner's failure to abide by it.

6.E ***Practitioner's Refusal to Provide Information or Meet with Medical Staff Leadership.***

(1) If the Practitioner fails or refuses to: (i) provide a written response to a request for information sent by the Medical Executive Committee, or (ii) meet with the Medical Executive Committee or other specified individuals when requested to do so in accordance with this Policy, the Practitioner will be required to meet with the Medical Executive Committee to discuss why the requested input was not provided or the meeting was not attended. Failure of the Practitioner to either meet with the Medical Executive Committee or provide the requested information prior to the meeting will result in the automatic relinquishment of the Practitioner's clinical privileges until the Practitioner meets with the Medical Executive Committee or the information is provided.

(2) If the Practitioner fails to meet with or provide input requested by the Medical Executive Committee within ninety (90) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

(3) The automatic relinquishment or resignation of appointment and/or clinical privileges described in this section are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

6.F ***Letters Placed in Practitioner's Confidential File.*** Copies of letters sent to the Practitioner as part of the efforts to address the Practitioner's conduct shall be placed in the Practitioner's confidential file. The Practitioner shall be given an opportunity to respond in writing, and the Practitioner's response shall also be kept in the Practitioner's confidential file.

6.G ***Additional Reports of Inappropriate Conduct.*** If additional reports of inappropriate conduct are received concerning a Practitioner, the Medical Executive Committee may continue to use the collegial and progressive steps outlined in this Section 6 as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

6.H ***Determination to Address Concerns through Practitioner Health Policy.*** The Medical Executive Committee may determine to address the conduct concerns through the Practitioner Health Policy if it believes that there may be a legitimate, underlying health issue that is causing the concerns, and the review process outlined in the Practitioner Health Policy is more likely to resolve the concerns.

7. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

7.A ***Referral to the Medical Executive Committee.*** At any point, the Medical Executive Committee may refer the matter to the Medical Executive Committee for review and action because:

(1) the Practitioner refuses to participate in a Performance Improvement Plan developed by the Medical Executive Committee;

(2) the Performance Improvement Plan options for conduct were unsuccessful; or

(3) the Medical Executive Committee otherwise determines that Medical Executive Committee review is required.

The Medical Executive Committee shall be fully apprised of the actions taken previously by the Medical Executive Committee to address the concerns. When it makes such a referral, the Medical Executive Committee may also suggest a recommended course of action.

7.B ***Medical Executive Committee Review.*** The Medical Executive Committee shall review the matter and take appropriate action in accordance with the Medical Staff Credentials Policy. These actions include all of the Performance Improvement Options set forth in **Appendix H**, as well as short-term suspensions, long-term suspensions, and/or the revocation of appointment and clinical privileges.

7.C ***Recommendation That Entitles Practitioner to a Hearing.*** If the Medical Executive Committee makes a recommendation that entitles the Practitioner to request a hearing under the Medical Staff Credentials Policy, the individual shall be provided with copies of all relevant reports so that he or she can prepare for the hearing, subject to a written agreement by the Practitioner and his/her counsel, if any, that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing.

8. REVIEW OF REPORTS OF IDENTITY-BASED HARASSMENT

8.A ***Definition.*** Identity-based harassment is verbal or physical conduct that: (i) is unwelcome and offensive to an individual who is subjected to it or who witnesses it; (ii) could be considered harassment from the objective standpoint of a "reasonable person"; and (iii) is covered by state or federal laws governing discrimination. Identity-based harassment includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination. Depending on the circumstances, any of the examples of inappropriate conduct described in Section 2 of this Policy may also qualify as identity-based harassment. Additional examples of identity-based harassment include, but are not limited to, the following:

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

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

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

(4) ***Other:*** retaliating or threatening retaliation as a result of an individual's complaint regarding harassment.

8.B ***General.*** All reports of potential identity-based harassment will be reviewed by the Medical Executive Committee in the same manner as set forth above. However, because of the unique legal implications surrounding identity-based harassment, a single confirmed incident requires the actions set forth below.

8.C ***Personal Meeting and Letter of Admonition and Warning.*** Two or more members of the Medical Executive Committee shall personally meet with the Practitioner to discuss the incident. If the Practitioner acknowledges the seriousness of the matter and agrees that there will be no repeat of such conduct, the meeting shall be followed with a formal letter of admonition and warning to be placed in the Practitioner's confidential file. This letter

shall also set forth any additional actions or conditions imposed on the Practitioner's continued practice in the Hospital as a result of the meeting.

8.D ***Referral to Medical Executive Committee.*** The matter shall be immediately referred to the Medical Executive Committee if:

(1) the Practitioner refuses to acknowledge the concern, does not recognize the seriousness of it, or will not agree that there will be no repeat of such conduct, or

(2) there are confirmed reports of retaliation or further incidents of identity-based harassment, after the Practitioner agreed there would be no further improper conduct.

The Medical Executive Committee shall conduct its review in accordance with the Medical Staff Credentials Policy. Such referral shall not preclude other action under applicable Human Resources policies.

APPENDIX B

PROFESSIONAL CONDUCT REPORTING FORM

For Use by Employees and Practitioners

Instructions: Please use this form to report all incidents of inappropriate conduct and unprofessional behavior. Attach additional sheets if necessary. Please provide the following information as ***specifically*** and as ***objectively*** as possible and submit the completed form to the Hospital PPE Support Staff.

DATE, TIME, AND LOCATION OF INCIDENT				
Date of incident:	Time of incident:		a.m.	
			p.m.	
Location of incident:				
Range of dates if your concerns are not limited to one particular event: _____/_____/20_____ to _____/_____/20_____				
PRACTITIONER INFORMATION				
Name of Practitioner exhibiting inappropriate professional conduct: _____				
PATIENT INFORMATION				
Was a patient directly or indirectly involved in the event?	**Yes** ❑	**No** ❑	Medical Record # _____	
Patient's Last Name: _____		Patient's First Name: _____		
DESCRIPTION OF INCIDENT				
Describe what happened as *specifically* and *objectively* as possible [attach additional pages if necessary]: _____ _____ _____				
OTHER INDIVIDUALS INVOLVED/WITNESSES				
Name(s) of other Practitioner(s) and/or Hospital employee(s) who witnessed this event: _____ _____ _____ _____				
Name(s) of any other person(s) who were involved in or witnessed this event (e.g., visitors; family members, representatives): _____ _____ _____ _____				

EFFECT OF CONDUCT		
How do you think this behavior affected patient care, Hospital operations, your work, or your team members' work? _____ _____ _____		
	Yes	**No**
Did you experience or witness any retaliation or threatened retaliation by the Practitioner?	❑	❑
If yes, please explain: _____ _____ _____		
RESPONSE TO CONDUCT	**Yes**	**No**
Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?	❑	❑
If yes, please explain and indicate by whom: _____ _____ _____		

CONTACT INFORMATION	
Your name:	Department:
Phone #:	Date this form completed:
E-mail address:	

Note: Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless: (a) you consent; (b) the Medical Executive Committee determines that an exception must be made in a particular situation to ensure an appropriate review, in which case you will be notified; or (c) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence). In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the Practitioner at issue may not approach you directly to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report that immediately to your supervisor, the Chief of the Medical Staff, or another Medical Staff leader.

APPENDIX C

LETTER TO RESPOND TO INDIVIDUAL WHO REPORTS AN INCIDENT OF INAPPROPRIATE CONDUCT*

Dear _____:

Thank you for reporting your concerns. We appreciate your participation in our efforts to promote and maintain a culture of safety and quality care at our Hospital.

Your concerns will be reviewed in accordance with the Medical Staff Professionalism Policy or other applicable policy. We will contact you if we need additional information.

Because your report may involve confidential matters under Texas law, we may not be able to inform you of the specific outcome of the review. However, please be assured that your report will be fully reviewed and appropriate steps will be taken to address the matter.

Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless: (a) you consent; (b) the Medical Executive Committee determines that an exception must be made in a particular situation to ensure an appropriate review, in which case you will be notified; or (c) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence). In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the individual who is the subject of your report may not approach you directly to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report it immediately to *[me/the PPE Support Staff/and/or Chief Medical Officer]*.

Once again, thank you for bringing your concerns to our attention. If you have any questions or wish to discuss this matter further, please do not hesitate to call me at _____.

Sincerely,

PPE Support Staff, Chief of the Medical Staff, or *Chief Medical Officer* [if applicable]

* ***As an alternative to sending a letter, the content of this letter may be used as talking points to respond verbally to the individual who reported a concern regarding conduct.***

APPENDIX D

PRELIMINARY NOTIFICATION INSTRUCTIONS AND FORM

I. MEDICAL STAFF LEADER PREPARATION PRIOR TO CONVERSATION

☐ Review Section 4.D of the Professionalism Policy ("Preliminary Notification to the Practitioner").

☐ Decide whether to provide preliminary notification in person or over the telephone. *E-mail is strongly discouraged*.

☐ If the Chief of the Medical Staff *or the Chief Medical Officer* is not able to provide preliminary notification in a timely manner, Section 3.F of the Professionalism Policy permits the President to delegate this function to a qualified designee.

☐ Be cognizant that no information should be provided to the Practitioner during the discussion that would identify anyone who filed the complaint or provided information about the matter.

☐ Be prepared to document any information the Practitioner provides about the incident in question on the Preliminary Notification Form, which is to be completed as soon as the notification is provided.

☐ Review and revise, as necessary, the general script for the conversation, which follows in Section II.

II. GENERAL SCRIPT FOR CONVERSATION WITH PRACTITIONER

☐ Notify the Practitioner that a concern about professionalism has been raised and that the purpose of this conversation is to provide a **BRIEF PRELIMINARY** notification to the Practitioner, in accordance with the Professionalism Policy.

☐ Inform the Practitioner that the matter is being reviewed and summarize how the review process works/next steps. ***(See next two bullets.)*** Offer to provide the Practitioner with a copy of the Professionalism Policy.

☐ Explain that if the report is determined to **NOT BE CREDIBLE**, the Practitioner will be informed and the review will be closed.

☐ Explain that if the report is determined to be **CREDIBLE**, the Practitioner will be given details of the concern and asked to provide his or her perspective on the incident, prior to the Medical Executive Committee taking any further action. However, the Practitioner is also free to submit input at any time, if the Practitioner would like to do so.

☐ Remind the Practitioner to avoid any action that could be perceived as **RETALIATION**. This includes speaking with anyone who the Practitioner may believe raised the concern or

provided information about the matter, because even well-intentioned conversations can be perceived as intimidating.

☐ Remind the Practitioner of the crucial importance of **CONFIDENTIALITY** to avoid waiving the protections offered by the state peer review protection law.

After the conversation, complete the Preliminary Notification Form that is set forth on the next page and include it in the Practitioner's Confidential File.

St. David's South Austin Medical Center

Appendix A: Review Process for Concerns Regarding Professional Conduct

Reported concern regarding professional conduct ***(See Note 1)***

PPE Support Staff (with Chief of the Medical Staff and CMO)

1. Log-in referral to peer review database
2. Follow up with individual who reported concern
3. Provide preliminary notification to Practitioner that concern has been raised (generally in person or via telephone)
4. Fact-finding to determine that report is credible, including interviews with witnesses and others
5. If report not credible, notify MEC (to allow for oversight of process and consistency) and notify Practitioner that complaint was dismissed
6. If report determined to be credible, obtain input from Practitioner (use cover letter or more formal agreement to remind Practitioner of confidentiality and non-retaliation obligations)
7. Prepare summary of matter for review by MEC

MEC

General Conduct Concern

1. Review summary report and all supporting documentation
2. Consult with or include Department Chair, if necessary or helpful in resolving concern
3. Meet with individuals involved and witnesses, if necessary
4. Appoint ad hoc committee to assess, if necessary
5. Meet with Practitioner, if necessary or if requested by Practitioner
6. Determinations/Interventions
   A. No issue
   B. Letter of guidance or counsel
   C. Collegial intervention, education, or coaching
   D. Performance Improvement Plan for Conduct (several options), or
   E. Refer to MEC

Identity-Based Harassment (single confirmed incident)

1. Practitioner acknowledges seriousness of matter, agrees there will be no similar conduct in the future
2. Formal letter of admonition and warning placed in file
3. If Practitioner does not acknowledge concern or seriousness, or there are additional incidents, refer to MEC

MEC Action

Review under Medical Staff Credentials Policy because individual refuses to cooperate, PIP Options for Conduct were unsuccessful, or MEC determines further review is required

Note 1: If the Practitioner involved is also employed by the Hospital or a Hospital-related entity, Medical Staff Leaders and appropriate representatives of the employing entity may determine that: (1) any review under this Policy will be held in abeyance pending the outcome of the review by the employing entity; but (2) the MEC may decide at any time to also review the matter under this Policy.

CONFIDENTIAL PEER REVIEW DOCUMENT

PRELIMINARY NOTIFICATION FORM

(to be completed by the Chief of the Medical Staff or the Chief Medical Officer)

Practitioner: _____

Department: _____

Date of Conversation: _____

Approximate Time of Conversation: _____

Did this conversation occur in person or via telephone call?	❑ In person	❑ Telephone
Was the script outlined in the Appendix D "Instruction" form substantially followed during the discussion?	❑ Yes	❑ No
Was the Practitioner advised not to retaliate?	❑ Yes	❑ No
Was the Practitioner advised of confidentiality requirements?	❑ Yes	❑ No
Was the Practitioner notified of opportunity to provide input, even at this preliminary stage of the review process?	❑ Yes	❑ No

Additional comments/summary of any information provided by the Practitioner:

_____

_____

_____

_____

_____

_____

Name and Title

_____

Signature

APPENDIX E

INTERVIEW TOOL (SCRIPT AND QUESTIONS)

I. SCRIPT FOR INTRODUCTORY STATEMENTS

Instructions: Prior to the interview, the following information should be provided to each individual who is interviewed.

1. A concern about a Practitioner's behavior is being reviewed under the Medical Center's Professionalism Policy. We would like to speak with you because you *[raised the concern]* **or** *[may have relevant information]*.

2. Any information you provide will be treated with the utmost confidentiality. It will not be shared with anyone outside the Medical Center's peer review process. Also, Medical Center policy states that your identity will generally not be disclosed to the Practitioner whose behavior is being reviewed except in extremely rare situations (for example, a Medical Staff hearing).

3. As part of our culture of safety and quality care, no retaliation is permitted against you for *[reporting this matter]* **or** *[providing information about this matter].* This means that the Practitioner under review may not approach you to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe you have been retaliated against, please report immediately to your supervisor or any Medical Staff Leader.

4. The West Virginia peer review protection law requires the Medical Center to maintain any information related to this review in a ***strictly confidential*** manner. Accordingly, if you have any questions about this review process, please direct them to the Chief Medical Officer or the PPE Support Staff.

II. SAMPLE INTERVIEW QUESTIONS

Note: The following questions are intended to elicit basic information about an incident. These questions may be modified as appropriate, and should be supplemented with additional questions that specifically pertain to the incident being reviewed.

1. What was the date of the incident?

2. What time did the incident occur?

3. Where did the incident occur?

4. What is the name of the Practitioner who behaved inappropriately?

5. Who was involved? What are their titles and duties?

6. What happened? What did you see and hear?

7. Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?

8. Are there any notes or other documentation regarding the incident(s)?

9. Was a patient or a patient's family member directly or indirectly involved in the event? If so, name and medical record number.

10. Did you tell anyone about the incident?

    a. Who did you tell?

    b. When and where did you tell them?

    c. What did you tell them?

11. How did you react to this incident at the time?

12. Did you experience or witness any retaliation or threatened retaliation by the Practitioner?

13. How do you think this incident affected patient care generally, Medical Center operations, the work of your team, or your ability to do your job?

14. Have other incidents occurred, either before or after this incident? ***[If yes, repeat above questions for each incident.]***

15. How would you like to see the situation resolved?

16. Do you have any other information we should know about this matter? Please contact me if you recall or learn something new after we are finished talking.

APPENDIX F

COVER LETTER TO PRACTITIONER
ENCLOSING INFORMATION ABOUT REPORTED CONCERNS

VIA HAND DELIVERY

[Date]

[Name]
[Address]

Re: Information Related to Behavioral Concerns

Dear _____:

As you know from our conversation, concerns have been raised about your professional conduct at _____ Hospital (the "Hospital"). As part of the review process, the Medical Executive Committee would like you to be fully aware of the relevant issues and have an opportunity to respond to them. Accordingly, enclosed is information that summarizes the concerns that have been raised.

The Medical Executive Committee would appreciate your perspective on these issues. Please provide your written response to me by _____ ***[date]***. *Optional: Specifically, please respond to the following questions: _____ [list specific questions, if any].*

Your input into these issues is essential as we attempt to achieve our goal of having a timely, fair, and constructive review process. If you do not respond to this request for information prior to the date in the preceding paragraph, your privileges may be deemed to be automatically relinquished as set forth in the Medical Staff Professionalism Policy until the information is provided.

Once the Medical Staff Executive Committee reviews your written input, it will decide whether it believes a meeting with you would be helpful to discuss this matter further. If so, we will contact you to arrange a meeting. If the Medical Staff Executive Committee believes a meeting is not necessary but you would nonetheless like to meet with the Council, you are welcome to meet with us at the next scheduled meeting of the Medical Executive Committee.

The Medical Executive Committee has an obligation to ensure that all peer review information is maintained in a confidential manner. The Medical Executive Committee also has an obligation to maintain a professional, non-threatening environment for all who work and practice at the Hospital.

Accordingly, we remind you of the following obligations that apply to all Medical Staff members, as set forth in the Medical Staff Professionalism Policy:

(1) You must maintain all information related to this review in a ***strictly confidential*** manner, as required by Texas law. Specifically, you may not disclose this information to, or discuss it with, anyone ***except*** the following individuals without first obtaining the written permission of the

Hospital: (i) the Medical Executive Committee (or its designees), or (ii) any legal counsel who may be advising you.

(2) You may not retaliate against anyone who you believe may have raised a concern about you, provided information regarding this matter, or otherwise been involved in the review process. ***This means that you may not, under any circumstances, discuss this matter with any such individual, nor may you engage in any other retaliatory or abusive conduct*** such as confronting, ostracizing, or discriminating against such individual.

Please recognize that any retaliation by you, as described in the previous paragraph, is a very serious matter and will be grounds for immediate referral to the Medical Executive Committee for its review and disciplinary action pursuant to the Credentials Policy.

Of course, you are fully permitted to raise any questions or concerns that you may have regarding the care being provided by a nurse or other Hospital employee, another Practitioner, or the Hospital itself. However, you must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.

Thank you for your attention to this matter.

Sincerely,

Chief of the Medical Staff

APPENDIX G

CONFIDENTIALITY AND NON-RETALIATION AGREEMENT

Concerns have been raised about my professional conduct at _____ Hospital (the "Hospital"). As part of the review process, the Medical Executive Committee would like me to be fully aware of the concerns, as well as have the ability to provide my perspective and any response that I believe may be necessary or appropriate.

However, the Medical Executive Committee also wants to take appropriate steps to maintain the confidentiality of the information under Texas and federal law, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, I agree to the following:

1. I will maintain all the information that I review in a ***strictly confidential*** manner. Specifically, I will not disclose or discuss this information ***except*** to the following individuals: (i) the Medical Executive Committee (or its designees), or (ii) any legal counsel who may be advising me. I will not share or discuss this information with any other individual(s) without first obtaining the express written permission of the Hospital.

2. I understand that this information is being provided to me as part of the Medical Staff's policy of attempting to utilize collegial intervention and progressive steps, where possible, to address any questions or concerns that may arise with my practice. In addition to discussing these matters directly with the Medical Executive Committee (or its designees), I understand that I may also prepare a written response and that this response will be maintained in my file.

3. I understand that the Hospital and Medical Staff have a responsibility to provide a safe, non-threatening workplace for my professional colleagues and for Hospital employees. I therefore agree that:

   (a) ***I will <u>not directly discuss</u> this matter with any individual who may have expressed concerns about me or otherwise provided information in this matter. I understand that the act of discussing this matter with any individual who may have raised a concern or provided information will be viewed as retaliation.***

   (b) I will not engage in any other retaliatory or abusive conduct with respect to these individuals. This means that I will not confront, ostracize, discriminate against, or otherwise mistreat any such individual with respect to any information that the individual may have provided.

4. I understand that any retaliation by me, as described in the previous paragraph, is a very serious matter and cannot be tolerated. Any such conduct by me will be grounds for immediate referral to the Medical Executive Committee for its review and disciplinary action pursuant to the Medical Staff Credentials Policy.

By signing this Agreement, I understand that I am ***<u>not waiving</u>*** any of the rights or privileges afforded to me under the Medical Staff Credentials Policy and related documents.

I also understand that I am fully permitted to raise any question or concern that I may have regarding the care being provided by a nurse or other Hospital employee, another Practitioner, or the Hospital itself. ***However, I understand that I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.*** These mechanisms are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff or Hospital leadership to fully review and assess the matter and take action to address the issue, as may be necessary.

_____ _____

_____, M.D./D.O. Date

Note: After this agreement is signed, a copy shall be returned to the Practitioner for reference.

APPENDIX H

PERFORMANCE IMPROVEMENT PLAN OPTIONS FOR CONDUCT

IMPLEMENTATION ISSUES CHECKLIST
(For use by the
Medical Executive Committee)

TABLE OF CONTENTS

PAGE

Note: The Implementation Issues Checklists in this Appendix may be used by the Medical Executive Committee and Medical Executive Committee in developing and monitoring Performance Improvement Plans ("PIPs"). Checklists may be used individually or in combination with one another, depending on the nature of the PIP.

A copy of a completed Checklist may be provided to the Practitioner who is subject to the PIP, so that the Medical Executive Committee and the Practitioner have a shared and clear understanding of the elements of the PIP. While Checklists may serve as helpful guidance, there is no requirement that they be used. Failure to use a Checklist or to answer one or more questions on a Checklist will not affect the validity of a PIP.

PIP OPTION	IMPLEMENTATION ISSUES
Meeting with Medical Executive Committee or Designated Group	***Who Should Meet with Practitioner?*** ❑ Medical Executive Committee ❑ Other Medical Staff Committee ❑ Other designated ad hoc group (may include Board Chair or other Board members), including: _____ ❑ May Practitioner bring a colleague (not legal counsel) to the meeting? ❑ Yes ❑ No Is pre-meeting to plan intervention necessary? ❑ Yes ❑ No If yes, where and when: _____ _____ ***Scheduling Meeting with Practitioner*** ❑ Date of meeting: _____ ❑ Time of meeting: _____ ❑ Location of meeting: _____ ***Notice of Meeting*** ❑ Notice of meeting sent by: ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* ❑ Chief Quality Officer ❑ Hospital CEO ❑ Other: _____ ❑ Practitioner notified that this is a peer review meeting with colleagues, therefore: ❑ No attorneys allowed at the meeting ❑ No audio or video recording of meeting ❑ Does notice state that failure to appear results in automatic relinquishment of clinical privileges? ❑ Yes ❑ No ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Documentation*** ❑ If not already provided, will documentation/substance of reports regarding inappropriate conduct be shared before or during meeting? ❑ Yes ❑ No ❑ If yes, has Practitioner been provided a cover letter or agreement explaining his/her obligation to maintain the confidentiality of the information and not to retaliate against any individual who may have reported? ❑ Yes ❑ No

PIP OPTION	IMPLEMENTATION ISSUES
Meeting with Medical Executive Committee or Designated Group ***(cont'd.)***	***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
Letters of Warning or Reprimand	***Drafting/Contents of Letter*** ❑ Who will draft the letter? ❑ Chief of the Medical Staff ❑ *Chief Medical Officer [if applicable]* ❑ Chief Quality Officer ❑ Hospital CEO ❑ Legal Counsel ❑ Other: _____ ❑ Practitioner informed that he/she may provide response for inclusion in file ❑ Copy included in Practitioner's credentials/quality file ***Review/Signature*** ❑ Who must review and approve the letter? ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* [if applicable] ❑ Chief Quality Officer ❑ Full Medical Executive Committee ❑ Individuals: _____ ❑ Who signs/sends the letter? ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* [if applicable] ❑ Chief Quality Officer ❑ Hospital CEO ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
Behavior Modification Course	***Scope of Requirement*** ❑ Acceptable programs include: _____ _____ ❑ Medical Executive Committee approval required before Practitioner enrolls: ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the behavior modification course? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination _____ ❑ Time Frame ❑ Practitioner must enroll by: _____ Date ❑ Program must be completed by: _____ Date ***Practitioner's Responsibilities*** ❑ Sign release allowing Medical Executive Committee to provide information to the behavior modification course (if necessary) and course to provide report to or Medical Executive Committee _____ _____ ❑ Practitioner must submit ❑ Documentation of successful completion signed by course director ❑ Other: _____ _____ ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)***	***Drafting/Contents of Personal Code of Conduct*** ❑ Who will draft the Personal Code of Conduct? ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* ❑ Chief Quality Officer ❑ Hospital CEO ❑ Legal Counsel ❑ Other: _____ ❑ Practitioner informed that he/she may provide response for inclusion in file. ❑ Copy of personal code of conduct included in Practitioner's credentials/ quality file. ❑ Is Practitioner required to agree in writing to abide by the personal code of conduct? ❑ Yes ❑ No If yes, written agreement to abide by personal code of conduct received on: _____ Date ❑ Does the personal code of conduct describe the following consequences of a confirmed violation? ❑ Yes ❑ No ***Consequence of first violation (e.g., final warning):*** _____ _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date ***Consequence of second violation (e.g., short-term suspension):*** _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date

PIP OPTION	IMPLEMENTATION ISSUES
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)*** ***(cont'd.)***	***Consequence of third violation (e.g., recommendation for disciplinary action, perhaps limited hearing):*** _____ _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date ***Review/Signature*** ❑ Who must review and approve the letter outlining the personal code of conduct? ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* ❑ Chief Quality Officer ❑ MEC ❑ Other Individuals: _____ ❑ Who signs/sends the letter outlining the personal code of conduct? ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* ❑ Chief Quality Officer ❑ Hospital CEO ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
Short-Term Suspension That Does Not Trigger a Hearing or Reporting ***(for use by Medical Executive Committee only)***	***Date/Duration of Suspension*** ❑ Suspension begins on: _____ Date ❑ Suspension ends on: _____ Date ***Patient Care Arrangements*** ❑ If suspension begins immediately, what arrangements are made for patients currently admitted? _____ ❑ What arrangements are made for on-call responsibilities? _____ ***Drafting/Contents of Notice of Suspension*** ❑ Who will draft the notice of suspension? ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* [if applicable] ❑ Chief Quality Officer ❑ Hospital CEO ❑ Legal Counsel ❑ Other: _____ ❑ Practitioner informed that he/she may provide response for inclusion in file. ❑ Copy of notice included in Practitioner's credentials/quality file. ***Review/Signature*** ❑ Who must review and approve the notice of suspension? ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* [if applicable] ❑ Chief Quality Officer ❑ MEC ❑ Other Individuals: _____ ❑ Notice of suspension signed by: ❑ Chief of the Medical Staff ❑ *Chief Medical Officer* [if applicable] ❑ Chief Quality Officer ❑ Hospital CEO ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____

PIP OPTION	IMPLEMENTATION ISSUES
Short-Term Suspension That Does Not Trigger a Hearing or Reporting ***(cont'd.)***	***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
"Other" ***Wide latitude to utilize other ideas as part of PIP, tailored to specific concerns*** ***Examples:*** • ***Practitioner must have a chaperone;*** • ***Practitioner must attend CME for communication issues;*** • ***Practitioner must study and present grand rounds on behavior/ patient safety connection;*** • ***Practitioner required to apologize in writing (letter must be approved before it is sent) or in person accompanied by appropriate Medical Staff leader.***	