

MARQUETTE GENERAL HEALTH SYSTEM

MEDICAL STAFF CONDUCT POLICY

I. POLICY STATEMENT

- A. All members of the MGHS Medical Staff (hereinafter referred to as "practitioners") practicing in the Hospital must treat others with respect, courtesy and dignity and conduct themselves in a professional and cooperative manner.
- B. This Policy outlines collegial and educational efforts to be used by Medical Staff leaders in order to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the disciplinary process in the Medical Staff Bylaws.
- C. This Policy is also intended to address sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.
- D. 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 sexual harassment are also critical.

II. DEFINITION AND EXAMPLES OF INAPPROPRIATE CONDUCT

To aid in both the collegial education of Medical Staff Members ("practitioners") and in the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

- threatening or abusive language directed at patients, other Medical Staff Members, or Hospital personnel (e.g., belittling, berating, and/or threatening another individual);
- degrading or demeaning comments regarding patients, families, Medical Staff Members, Hospital personnel, or the Hospital;
- profanity or similarly offensive language while in the Hospital and/or while speaking with Medical Staff Members or other Hospital personnel;
- inappropriate physical contact with another individual that is threatening, intimidating, or unwelcome;
- inappropriate medical record entries critical of the Medical Staff or personnel concerning the quality of care being provided in the Hospital, any individual provider, or otherwise;
- refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentialing Policy, and Rules and Regulations, and failure to participate on and/or attend meetings of assigned committees;
- "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:
 - (a) Verbal
 - (b) Inappropriate Gestures
 - (c) Physical

- Making or threatening retaliation as a result of an individual reporting any of the above actions.

III. GENERAL GUIDELINES/PRINCIPLES

- A. Issues of employee conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Issues of conduct by members of the Medical Staff will be addressed in accordance with this Policy.
- B. Every effort will be made to coordinate the actions contemplated in this Policy with the provisions of the Medical Staff Bylaws. In the event of any apparent or actual conflict between this Policy and the Medical Staff Bylaws, the provisions of the Medical Staff Bylaws shall control.
- C. This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken in an attempt to resolve complaints about inappropriate conduct exhibited by practitioners. However, there may be a single incident of inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and requires initiation of immediate corrective action in accordance with Section 7.2 of the Medical Staff Bylaws. Therefore, nothing in this Policy precludes an immediate referral to the Executive Committee or the elimination of any particular step in the Policy when dealing with a complaint about inappropriate conduct.
- D. The Medical Staff leadership and Hospital Administration shall provide orientation and education to make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy. The Medical Staff leadership and Hospital Administration shall facilitate prompt reporting of conduct which may violate this Policy and prompt action as appropriate under the circumstances.

IV. PROCEDURE WHEN A CONCERN IS RAISED

A. REPORTING.

1. Any medical staff member, employee, patient or visitor may report potentially disruptive conduct on the prescribed medical staff conduct incident report form. The report may be submitted to an immediate supervisor or the Chief Executive Officer (CEO).
2. The identity of an individual reporting a medical staff conduct incident will generally not be disclosed to the practitioner unless the Chief of Staff (COS) deems it appropriate to do so.

B. DOCUMENTATION. Documentation of disruptive conduct is critical because it is ordinarily not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. Such documentation on the medical staff incident report form shall include:

1. Date, time, and location of the incident;
2. Name of the individual engaging in improper conduct;
3. Statement of whether the behavior affected or involved a patient in any way, and, if so, the name of the patient or patient family member who may have been involved in the incident or may have witnessed the incident, and the names of any other witnesses to the incident;
4. Circumstances which precipitated the incident and a description of the questionable behavior limited to factual, objective language; Consequences of the behavior (if any) related to patient care, personnel, or Hospital operations;

5. Any action taken to intervene in, or remedy, the incident; and
 6. Name and signature of the individual reporting the complaint of inappropriate conduct and date and time of report, and the name of the individual to which the report was referred and date and time of referral.
- C. **ADMINISTRATIVE STEPS.** Upon receipt of a report of disruptive conduct by the supervisor or administration the following shall occur:
1. The COS (Chief of Staff), in consultation with the CMO (Chief Medical Officer), will assist in investigating the report. The COS has the authority to dismiss unfounded reports, and the individual initiating such report will be notified. Those reports considered accurate will continue through the following steps.
 2. The practitioner shall be advised that any retaliation against the person reporting a concern, whether the identity is disclosed or not, will be grounds for immediate disciplinary action pursuant to the Medical Staff Bylaws.
 3. A single, confirmed incident warrants a discussion with the offending practitioner; the COS, CMO, or designee shall initiate such discussion and emphasize that such conduct is inappropriate and must cease. The initial meeting should be an attempt to be educational and helpful to the practitioner.
 4. After an initial meeting, follow up meetings may be held or a referral to the Health and Well Being Committee may be made as deemed appropriate by the COS or CMO.
 5. If it appears to the COS and CMO that a pattern of disruptive behavior is developing, the COS, CMO, or designee shall discuss the matter with the practitioner as outlined below:
 - Emphasize that if such repeated behavior continues, more formal action will be taken to stop it. The CEO and Medical Staff Executive Committee shall be notified.
 - All meetings shall be documented.
 - A follow-up letter shall be sent to the practitioner stating the nature of the problem and informing them that he or she is required to behave professionally and cooperatively within the hospital. A copy of documentation shall be kept in the practitioner's confidential file.
 - The involved practitioner may submit a written rebuttal to the charge. A copy of such rebuttal shall be kept in the practitioner's confidential file along with the original concern.
 6. If such behavior continues, the matter shall be referred to the Medical Staff Executive Committee (MSEC) and CEO for review and action. The MSEC shall be fully apprised of the previous warnings issued to the practitioner and actions taken to address the concerns, and may suggest a recommended course of action. The MSEC may, at any point in the investigation, refer the matter to the Board of Trustees without a recommendation. Any further action, including any hearing or appeal, shall then be conducted under the direction of the Board.
 7. Single incidents of misconduct or a continuation of misconduct may be so unacceptable that it may warrant initiation of immediate corrective action, including suspension, as prescribed in Section 7.2, Summary Action, in the Medical Staff Bylaws. The CEO and COS will determine if an incident is so egregious as to warrant initiation of such immediate corrective action.

This policy shall be the sole process for dealing with egregious incidents and disruptive behavior, and shall be interpreted and enforced by the Board of Trustees. No other policy or procedure shall be applicable to egregious incidents or disruptive behavior except as prescribed in the Medical Staff Bylaws or designated by the Board.

V. SEXUAL HARRASSMENT CONCERNS

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the actions set forth as follows:

1. A meeting shall be held with the practitioner to discuss the incident. If the practitioner has agreed to stop the conduct thought specifically to constitute sexual harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's quality file. This letter shall also set forth those additional actions, if any, resulting from the meeting.
2. If the practitioner refuses to agree to stop the conduct immediately, this refusal shall result in the matter being referred to the Executive Committee to be formally investigated pursuant to the Credentialing Policy.
3. Any reports of retaliation or any further reports of sexual harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate investigation by the COS, CMO, or designee. If the investigation results in a finding that further improper conduct took place, a formal investigation in accordance with the Medical Staff Bylaws shall be conducted. Should this investigation result in an action that entitles the individual to request a hearing under the Medical Staff Bylaws, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.
4. In order to effectuate the objectives of this Policy, and except as otherwise may be determined by the COS or CMO, or prescribed in the Medical Staff Bylaws or General Rules of the Medical Staff, the medical staff member's counsel shall not attend any of the meetings described above.

Recommended by the Medical Staff Executive Committee this ____ day of _____, 2006.

Kenneth A. Davenport, MD
COS

Approved by the Board of Trustees this ____ day of _____, 2006.

Timothy J. Larson, Chair
Board of Directors