

PROFESSIONAL BEHAVIOR POLICY
(EFFECTIVE 2006)

POLICY STATEMENT:

It is the policy of CHRISTUS Health that all individuals within its facilities be treated with respect, courtesy and dignity. CHRISTUS promotes a work environment consistent with the CHRISTUS Mission, Core Values and Associate Covenant - a workplace filled with hope, dignity and mutual respect. CHRISTUS values its relationships with physicians and has adopted a "Physician Compact" that details mutual commitments to be demonstrated through organizational and personal behavior. In particular, CHRISTUS and physicians commit to behaviors that exhibit respect and honor the dignity of all Associates and health care partners, patients and their families

POLICY:

CHRISTUS Core Values

- Dignity: Respect for the worth of every person with special concern for the poor and underserved.
- Integrity: Honesty, justice, and consistency in all relationships.
- Excellence: High standards of service and performance.
- Compassion: Service in a spirit of empathy, love, and concern.
- Stewardship: Wise and just use of talents and resources in a collaborative manner.

To this end, CHRISTUS St. Michael and the Medical Staff are committed to promoting a safe, cooperative, and professional health care environment. Therefore, the CHRISTUS Health Board of Directors requires that all individuals, associates, physicians, and other independent practitioners conduct themselves in a professional, cooperative, and respectful manner in the hospital. In dealing with all incidents of inappropriate conduct, the protection of patients, associates, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. This policy shall be enforced in a firm, fair, and equitable manner. This policy is applicable to unprofessional conduct, which may adversely affect patient care, and is therefore a concern of both the CHRISTUS Health Board of Directors and the CHRISTUS St. Michael Medical Staff. To ensure an appropriate environment in which quality patient care is the primary goal, the clinical privileges of the practitioner whose behavior is at issue may be suspended on a temporary or permanent basis as the circumstances may require.

I. DEFINITIONS and APPLICABILITY

Issues of associate conduct will be dealt with in accordance with Human Resource Policies. Issues of conduct by members of the Medical Staff will be addressed in accordance with this Policy.

- a. Medical Staff shall include: (this definition should be the definition from the medical staff bylaws that includes all practitioners that are credentialed at your facility, i.e. MD, DO, AHP etc). For purposes of this policy all members of the Medical Staff (as defined above) are required to abide by the guidelines of professional conduct outlined in this policy. Any of the corrective actions outlined in section IV may be applied to all Medical Staff members, however those Medical Staff members who are considered (insert here the language used in your bylaws to describe solely the non-physician staff such as AHP or scientific staff) are not entitled to the Due Process procedures described herein, but rather may be entitled to the Due Process procedures described in the Medical Staff Bylaw specific to those practitioners.
- b. Regional Governing Board shall mean those persons selected to act within delegated limits as the governing body of the Hospital (and shall include any committee of the Region Board

whose members are exercising the powers of the Region Board) who, acting as a group, exercise the ultimate authority with respect to all public affairs, administrative affairs and oversight of the medical affairs of the Hospital.

- c. The term “adversely affecting” includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.
- d. Professional review action means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician.
- e. Review Committee means the Panel of individuals selected to participate in the review of the adverse recommendation.

PROCEDURE

II. GUIDELINES

Medical Staff members should conduct themselves in a reasonable and professional manner, by way of example Medical Staff members should:

- a) Comply consistently with practice standards for professionalism.
- b) Communicate with colleagues clearly and directly, displaying respect for their dignity.
- c) Support policies promoting cooperation and efficient teamwork.
- d) Use conflict resolution and mediation skills to manage disagreements.
- e) Address concerns about clinical judgments with team members directly and in private.
- f) Address dissatisfaction with practice policies through appropriate grievance channels.
- g) Routinely offer and accept constructive feedback.

Common behaviors which are unprofessional and/or disruptive

Inappropriate anger or resentments

- Intimidation
- abusive language
- blames or shames others for possible adverse outcomes
- unnecessary sarcasm or cynicism
- threats of violence, retribution, or litigation

Inappropriate words or actions directed toward another person

- sexual comments or innuendoes
- sexual harassment
- seductive, aggressive, or assaultive behavior
- racial, ethnic, or socioeconomic slurs
- lack of regard for personal comfort and dignity of others

Inappropriate response to patient needs or staff requests

- late or unsuitable replies to pages or calls
- unprofessional demeanor or conduct
- verbal or physical attacks leveled at other members of the staff or members of the hospital community
- uncooperative, defiant approach to problems
- rigid, inflexible responses to requests for assistance or cooperation
- impertinent and inappropriate comments or illustrations made in the patient medical record or other official facility documents impugning the quality of care, staff and/or associates or facility policies

III. INVESTIGATION AND DOCUMENTATION

Complete and accurate investigation and documentation of disruptive conduct is critical. Ordinarily it is not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. However, a single egregious incident may result in the imposition of any one or more corrective action(s) as outlined below.

- a) Staff Members, associates, patients, family members or visitors who observe behavior by a Medical Staff Member which disrupts the smooth operation of the Hospital, or adversely impacts patient care, shall document and report the incident. The report and/or subsequent documentation should include as much information as possible:
 - i. Date, time, location and description of the behavior, limited to factual objective language;
 - ii. If the behavior was in the presence of the patient, or affected or involved a patient in any way, the name of the patient;
 - iii. Circumstances which precipitated the situation;
 - iv. Consequences, if any, of the disruptive behavior as it relates to patient care, or personnel, or Hospital operations and any action taken, if any; including date, time, place, action and name(s) of those intervening; and
 - v. List of witnesses to the incident.
- b) The Report should be submitted to Administration who will then route it to the Vice President of Medical Staff Affairs (“VPMA”). The VPMA, in consultation with the president of the medical staff, will investigate the report. The investigation should include interviewing the person submitting the complaint and other witnesses or patients involved. The VPMA or the president of the medical staff will then inform the Staff Member of the report and advise him/her of the allegations and require the Staff Member responds to the allegation. The Staff Member has the right to submit a written rebuttal to the allegation. Such rebuttal will be maintained as a permanent part of the record. The Staff Member will be informed that any attempt to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question or who participated in the investigation is a violation of this policy and grounds for further disciplinary action. Reports determined to be unsubstantiated or insignificant may be dismissed although a record of the investigation will be maintained in the Medical Affairs office.

IV. REPORTS THAT WARRANT FURTHER INVESTIGATION and/or ACTION

Unless deemed to be insignificant or not credible a follow up discussion with the physician is warranted, either through referral to the appropriate committee or through an individual meeting with the physician. The decision for referral and handling will be at the discretion of the CEO or his/her designee, VPMA, and a quorum from the Medical Executive Committee (MEC) (quorum may be attained via telephonic). After investigation of the incident and input from the involved Staff Member the CEO or his/her designee, VPMA, and a quorum from the MEC or the appropriate committee (whichever handled the investigation) may recommend to the MEC any of the following actions, including but not limited to:

- a) No action.
- b) A follow-up meeting with the VPMA and/or other Department/Section Chief or Medical Director.
- c) The practitioner to meet with the full Medical Executive Committee.
- d) Letter of reprimand from the VPMA, the President of the Medical Staff, or the investigating committee, warning that such behavior is not acceptable and must cease.
- e) The letter should emphasize that if the disruptive behavior recurs, the Medical Staff and/or the Board will take more formal action.
- f) Letter of reprimand and final warning. This letter is not a request for further discussion, but rather constitutes the physician’s final warning.
- g) Recommendation for counseling, psychiatric counseling or other appropriate behavior modification course.
- h) Impose a “personal” code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner’s adherence to it.

*The imposition of any of the above actions does not entitle the practitioner to a due process hearing

V. PATTERN OF BEHAVIOR

In the case of a pattern of behavior the VPMA, president of the medical staff and/or the facility CEO may hold a series of meetings with the Medical Staff Member or the appropriate committee may schedule follow up meetings. The intervention involved in each meeting will progressively increase in severity until the behavior in question ceases. However, at any point in the discussions, at the sole discretion of the VPMA, the president of the medical staff and the facility CEO, the physician will be informed that such conduct is intolerable and will inform the individual that a single recurrence of the offending behavior shall result in a recommendation of termination of medical staff membership and privileges. This meeting is not a discussion, but rather constitutes the physician's final warning. The physician will also receive a follow-up letter that reiterates the final warning.

VI. ADMINISTRATIVE COOLING OFF PERIOD

In the case of egregious behavior, or behavior that is disruptive to patient care and/or behavior that has had a serious impact on an associate or other person within the facility the (each Medical staff could decide who has this authority but I recommend including at a minimum the Board chair) President of the Medical Staff, the VPMA, the Chief Executive Officer of the Hospital or the Chairperson of the Regional Governing Board may impose a "Cooling off Period" for a period of less than fourteen (14) days during which time the Staff Member may not engage in clinical management of patients nor perform any administrative duties at the Hospital. The Staff Member will be given an opportunity to arrange for his/her patients currently in the Hospital to be cared for by another qualified Staff Member or to be discharged if appropriate. During this time period the Staff Member will not be permitted to schedule any elective admissions, surgeries or procedures. The imposition of such an action shall be based on the reasonable belief that the action was necessary in the furtherance of quality care. This cooling off period is intended to serve as a process to ensure the integrity of patient care and the safety and concern for associates while further investigation is conducted; or in the alternative to serve as a final warning prior to or in lieu of a formal recommendation to suspend or terminate the Staff Member privileges and membership. The imposition of a cooling off period does not trigger the provisions of the Fair Hearing Plan/Appeals process of the Medical Staff Bylaws.

DUE PROCESS PROCEEDING SPECIFIC TO THIS POLICY

Other than the actions described above, any professional review action other than that is considered adverse as defined in section 12.1 of the Medical Staff Bylaws will proceed as described by the Due Process Procedure outlined below:

The professional review action must be taken—

- a) In the reasonable belief that the action was in the furtherance of quality health care,
- b) After a reasonable effort to obtain the facts of the matter,
- c) After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
- d) In the reasonable belief that the action was warranted by the facts known after such

Adequate Notice and Hearing

If a recommendation has been approved by the MEC to recommend suspension (for greater than fourteen days) or termination of the privileges and membership of a Staff

Member the Administrator/CEO shall send notice to the physician stating:

- a) that a professional review action has been proposed to be taken against the Physician;
- b) reasons for the proposed action;
- c) that the physician has the right to request a hearing on the proposed action, and that failure to request such a review shall constitute an acquiesce in the recommendation and a waiver of any rights or any hearing to which the Staff Member might otherwise have been entitled.
- d) that the physician has 30 days within which to request such a hearing; and
- e) a summary of the rights in the hearing which are as follows, these rights to be specifically delineated in the notice letter to the physician:

*** In the hearing physician involved has the right:**

1. To representation by an attorney or other person of the physician's choice;
2. To have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof;
3. To call, examine, and cross-examine witnesses;
4. To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and
5. To submit a written statement at the close of the hearing

*** Upon completion of the hearing, the physician involved has the right:**

6. To receive the written recommendation of the arbitrator, officer, or panel, including to the MEC who shall make a recommendation to the Board for final disposition; and
 7. To receive the final written decision of the Board, (or Board committee acting with the full authority of the Board) including a statement of the basis for the decision.
 8. The Physician shall have thirty (30) days from the delivery of the notice to request a review of the recommendation. The written request for the review should be submitted to the Administrator/CEO of the Hospital.
- f. Notice of hearing. If a hearing is requested on a timely basis the Administrator will give notice to the physician involved, such notice to include:
1. The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and
 2. A list of the witnesses (if any) expected to testify at the hearing on behalf of the individual(s) or committee which has made the recommendation.
 3. The requesting Staff Member shall be notified at least ten (10) days in advance of the time and place of such review, which review shall be conducted no less than thirty (30) days after the original notice of adverse action and no more than forty-five (45) days following the receipt of the request for a hearing.
- g. Conduct of hearing and notice. If a hearing is requested on a timely basis the hearing shall be conducted in one of the three following ways: (as determined by the health care entity);
1. Before a panel of no less than 5 individuals, the panel to include at least one member of the Hospital the Board who are appointed by the Chairperson of the Board in consultation with the President of the Medical Staff. All other members of the Panel to be physician members of the Medical staff that are not in direct economic competition with the physician.
- h. The Board Chair in consultation with the President of the Medical staff will decide whether or not the Panel will be chaired by;
1. An arbitrator who is not in direct economic competition with the Physician involved; or
 2. A hearing officer who is not in direct economic competition with the physician involved; or
 3. The Panel may elect their own chair from among their members.
- i. If due to the size of the medical staff it is impossible to appoint sufficient physician members who are not in direct economic competition with the physician the Chair of the Board in consultation with the President of the Medical Staff may appoint other Physicians from the nearby region or community who are on the staff at a CHRISTUS facility.
1. The arbitrator, presiding officer or the Chair, as the case may be, shall have the following authority and responsibility:
 - a. To rule on request for postponements of the hearing beyond the time set forth herein.
 - b. To ensure that all parties have a reasonable opportunity to present relevant evidence and that decorum is maintained at all times.

- c. To participate in the deliberations of, and act as an advisor to the review committee, but shall not vote except when there is a tie vote among the members of the Review Committee.
 - d. To recess the hearing and reconvene the same from time to time without special notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.
2. Upon conclusion of the evidence the hearing shall be closed. The Review Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Staff Member and the individual or committee representative bringing forth the recommendation for adverse action. Upon conclusion of deliberations of the Review Committee, the hearing shall be declared adjourned.
 3. Report. Within seven (7) days after adjournment of the hearing, the Review Committee shall prepare a written report of its findings and recommendation and shall forward the same together with the hearing record, to the MEC, via the Administrator.
 4. At the next regularly scheduled MEC, or pursuant to the Bylaws, at a specially called meeting of the MEC, the MEC shall render a final recommendation. The final written recommendation, together with the report of the Review Committee shall be forwarded to the CEO/Administrator who shall forward same to the Board.
 5. Quorum; Three (3) members of the Review Committee shall constitute a quorum. The arbitrator, presiding officer or the Panel chair shall count as a member for purposes of constituting a quorum.

**** Please note in Texas the provisions for mediation apply and so we need to discuss at that point in the process the medical staffs in Texas would like to offer the medication. Other states would skip this section and move to the final decision section. *****

**THE DECISION OF THE BOARD IS FINAL, THERE IS NO FURTHER RIGHT TO APPEAL VIII)
CONFIDENTIALITY/ IMMUNITY and RECORDS**

1. Actions taken and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as maybe adopted by the Board. In addition, reports of actions taken pursuant to this policy shall be made by the Chief Executive Officer/Administrator or designee to such governmental agencies as may be required by law.
2. All minutes, reports, recommendations, communications, and actions made or taken are deemed to be covered by the provisions of state law and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities, and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.
3. To the fullest extent permitted by law, the Medical Staff Member subject to this Policy releases from any and all liability, and extends absolute immunity to the Hospital, the Medical Staff, the Board, its authorized representatives and any third parties with respect to any acts, communications or documents, recommendations or disclosures concerning issues handled pursuant to this Policy.
4. Records. The Medical Staff office will maintain all reports and documents in a confidential peer review file. At the time of reappointment any such reports and investigation will be reported to the Section Chief / Department Chair for consideration in the reappointment process.
5. All meetings shall be documented in writing. When necessary, follow-up letters will be sent to the Physician involved documenting the content of the discussion and any specific action the Physician has agreed to.
6. The Physician will be informed that any attempt to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question or who participated in the investigation is a violation of this policy and grounds for further disciplinary action.