APPENDIX B

SHADY GROVE MEDICAL CENTER
MEDICAL STAFF POLICY

CODE OF CONDUCT

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I. Policy Statement

1. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all Medical Staff members and Advanced Practice Professionals (APP) practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

2. This Policy outlines collegial and educational efforts that can be used by Medical Staff leaders 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 Corrective Action Process in the Bylaws Manual.

3. This Policy also addresses sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.

4. In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians, 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.

5. All efforts undertaken pursuant to this Policy shall be part of the Hospital's performance improvement and professional and peer review activities.

II. EXAMPLES OF INAPPROPRIATE CONDUCT

To aid in both the education of Medical Staff members and Advanced Practice Professionals (APP) and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

- threatening or abusive language directed at patients, nurses, Hospital personnel, Advanced Practice Professionals (APP) or other physicians (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies incompetence);

- degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;

- profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;

- inappropriate physical contact with another individual that is threatening or intimidating;

- defamatory comments about the quality of care being provided by the Hospital, another Medical Staff member, or any other individual, outside of appropriate Medical Staff and/or administrative channels;

- inappropriate medical record entries impugning the quality of care being provided by the Hospital, Medical Staff members or any other individual;

- imposing onerous requirements on the nursing staff or other Hospital employees;

- refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentials Manual, and Medical Staff Rules and Regulations and Medical Staff Clinical Practice Expectations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical and Hospital Staffs); and/or

- "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: innuendo, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

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

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

  (d) Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

- creating or contributing to a hostile work environment. Examples include, but are not limited to the following:

  (a) Verbal: using threatening language

  (b) Visual/Non-Verbal: throwing objects and using threatening gestures

III. GENERAL GUIDELINES/PRINCIPLES

1. Issues of conduct by members of the Medical Staff or Advanced Practice Professionals (APP) (hereinafter referred to as "practitioners") will be addressed in accordance with this Policy.

2. This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address complaints about inappropriate conduct by practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the MEC or the President of the Medical Staff or the elimination of any particular step in the Policy for necessary immediate action.

3. In order to effectuate the objectives of this Policy, and except as otherwise may be determined by the Professional Review Committee ("PRC") (or its designee), the practitioner's counsel, partners or other department members shall not attend any of the meetings described in this Policy. The PRC is composed of the Chief Medical Officer and the President and Vice President of the Medical Staff.

4. The Medical Staff leadership and Hospital Administration shall make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy and shall institute procedures to facilitate prompt reporting of inappropriate conduct and prompt action as appropriate under the circumstances.

IV. REPORTING OF INAPPROPRIATE CONDUCT

1. Nurses and other Hospital employees who observe, or are subjected to, inappropriate conduct by a practitioner shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, shall notify any member of the PRC. Any practitioner who observes such behavior by another practitioner shall notify any member of the PRC (or its designee) directly.

2. The individual who reports an incident shall be requested to document it in writing via the hospital's online incident reporting program via the Intranet. If he or she does not wish to do so, the supervisor or PRC member may document it, after attempting to ascertain the individual's reasons for declining and encouraging the individual to do so.

3. The documentation should include:

   (a) the date and time of the incident

   (b) a factual description of the questionable behavior

   (c) the name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident

   (d) the circumstances which precipitated the incident

   (e) the names of other witnesses to the incident

   (f) consequences, if any, of the behavior as it relates to patient care, personnel, or Hospital operations

   (g) any action taken to intervene in, or remedy, the incident; and

   (h) the name and signature of the individual reporting the matter.

4. The supervisor/PRC member shall forward the report to the PRC.

V. INITIAL PROCEDURE

1. The PRC or designee shall review the report and may meet with the individual (or their designee) who prepared it and/or any witnesses to the incident to ascertain the details of the incident.

2. If the PRC or designee determines that an incident of inappropriate conduct has likely occurred, the PRC or designee has several options available to it, including, but not limited to, the following:

   - notify the practitioner that a complaint has been received and invite the practitioner to meet with one or more members of the PRC to discuss it;
   - refer the incident to the department/section chair to be addressed at the discretion of the PRC;
   - send the practitioner a letter of guidance about the incident;

- educate the practitioner about administrative channels that are available for registering complaints or 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, as appropriate;

- send the practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing; and/or

- have a PRC member(s), or the PRC as a group, meet with the practitioner to counsel and educate the individual about the concerns and the necessity to modify the behavior in question.

3. The identity of an individual reporting a complaint of inappropriate conduct will generally not be disclosed to the practitioner during these efforts, unless the PRC members agree in advance that it is appropriate to do so. In any case, the practitioner shall be advised that any retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate referral to the Credentials Committee or MEC pursuant to the Bylaws Manual.

4. If additional complaints are received concerning a practitioner, the PRC may continue to utilize the collegial and educational steps noted in this Section as long as it believes that there is still a reasonable likelihood that those efforts will resolve the concerns.

VI. Referral to the Medical MEC or Credentials Committee

1. At any point, the PRC may refer the matter to the Medical MEC or Credentials Committee for review and action. The Committee shall be fully apprised of the actions taken by the PRC or others to address the concerns. When it makes such a referral, the PRC may also suggest a recommended course of action.

2. The Executive or Credentials Committee may take additional steps to address the concerns including, but not limited to:

   - require the practitioner to meet with the Board Chair or other Board members;

   - require the practitioner to meet with the full MEC or Credentials Committee;

   - issue a letter of warning or reprimand;

   - require the practitioner to complete a behavior modification course;

   - impose a "personal" code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner's adherence to it; and/or

   - suspend the practitioner's clinical privileges for less than 30 days.

   The imposition of any of these actions does not entitle the practitioner to a hearing or appeal. Please refer to the Medical Staff Bylaws Article VII: Remedial Action and Article VIII: Rights to Hearing and Appeal.

3. The MEC may also direct that a matter be handled pursuant to the Health Policy.

4. At any point, the MEC may also make a recommendation regarding the practitioner's continued appointment and clinical privileges that does entitle the practitioner to a hearing as outlined in the Credentials Policy, or may refer the matter to the Board without a recommendation. If the matter is referred to the Board, any further action, including any hearing or appeal, shall be conducted under the direction of the Board.

VII. Sexual Harassment Concerns

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions at minimum, subject to further actions by the MEC

1. A meeting shall be held with the practitioner to discuss the incident. If the practitioner agrees 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 file. This letter shall also set forth those additional actions, if any, which result from the meeting.

2. If the practitioner refuses to stop the conduct immediately, this refusal shall result in the matter being referred to the MEC for review pursuant to the Bylaws Manual.

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 PRC (or its designee(s)). If the investigation results in a finding that further improper conduct took place, a formal investigation in accordance with the Credentials Policy shall be conducted. Should this investigation result in an action that entitles the individual to request a hearing under the Bylaws Manual, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.