MEDICAL STAFF BYLAWS

APPENDIX "C"

HOSPITAL POLICY REGARDING
DISRUPTIVE *PRACTITIONERS* CONDUCT

For purposes of this policy, "disruptive conduct" is any conduct, which disrupts the smooth operation of the Hospital, poses a threat to patient care or exposes the Hospital and/or Medical Staff to liability. Such disruptive conduct may include, but is not limited to, behavior such as:

1. Attacks-verbal or physical-leveled at other appointees to the medical staff, hospital personnel, patients or visitors, that are personal, irrelevant, or beyond the bounds of fair professional conduct.

2. Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, or inappropriate written or verbal statements to patients and/or members of the community impugning the quality of care in the hospital, or attacking particular physicians, nurses, other employees, or hospital policies.

3. Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

4. Refusal to accept-or disruptive acceptance of-medical staff assignments or participation in committee or departmental affairs regarding anything but his or her own terms.

5. Sexual, racial or other harassment.

Objective

The objective of this policy is to ensure quality patient care by promoting a safe, cooperative, and professional health care environment, and to prevent or eliminate, to the extent possible, conduct that:

1. Disrupts the operation of the hospital;
2. Affects the ability of others to do their jobs;
3. Creates a "hostile work environment" for hospital employees or other medical staff members;
4. Interferes with an individual's ability to practice competently; or
5. Adversely affects or impacts the community's confidence in the hospital's ability to provide quality patient care.

Documentation of Disruptive Behavior

1. Documentation of disruptive conduct is critical. Physicians, nurses and other hospital employees who observe or are otherwise made aware of disruptive behavior by a practitioner, must document the behavior. Whenever possible, the behavior shall be documented on the attached Disruptive Practitioner Behavior Report Form (the "Report") (attached hereto as ("Exhibit A"). The documentation shall include:

   (a) the name of the practitioner(s) involved in the questionable behavior;

   (b) the date and time of the questionable behavior;

   (b) a statement of whether the behavior affected or involved a patient in any way; and if so, the chart number of the patient;

   (c) the circumstances which precipitated the situation;

   (d) a description of the questionable behavior limited to factual, objective language as much as possible;

   (e) the consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;

   (f) a record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

2. Once the report is received by the CEO, the CEO shall provide a copy of the Report to the Chief of Staff. In performing all functions hereunder, the Chief Executive Officer and Chief of Staff shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

Investigation

1. Once received, a report will be investigated by the CEO and the Chief of Staff. As part of the investigation, the CEO will interview the employee or other person completing the report as soon as reasonably practical, usually within two business days of having received the Report, in order to gather additional, more complete information. If the CEO is unable to complete the report within this time period, the documentation of the investigation will indicate why the interview could not occur within two business days. The CEO will document the time, date and substance of this meeting, and such documentation will be made a part of the investigative file.

2. In general, investigations of disruptive conduct should be completed within three business days after the initial interview of the complaining party, whenever practical. Once an investigation is completed, the CEO will follow-up with the reporting employee or other individual to inform them (in general terms and without disclosing peer review information or other confidential or sensitive information), of the conclusions of the investigation, and that appropriate actions will

be taken. The employee or person reporting should be encouraged to report any further disruptive behavior. In addition, the employee or other reporting individual shall be advised that retaliatory action will not be tolerated, and will be encouraged to report any action which appears to have been taken in retaliation for reporting of the disruptive conduct.

3. Reports which are determined to be credible, based on the facts and information gathered during the investigation, will be addressed through the procedure set out below and will become a part of the physician's quality credential file. If the report is determined to be credible, the practitioner who is the subject of the report shall be interviewed prior to conclusion of the investigation.

4. If at any time it appears to the Chief of Staff, the CEO or any committee charged with implementation of this policy that a practitioner's behavior may result from an impairment, the procedure set forth in the impaired practitioner policy shall be followed.

Progressive Corrective Action

1. A single confirmed incident warrants a formal discussion with the offending practitioner. This meeting may be held in conjunction with the interview described in Paragraph 3 above. The Chief of Staff and CEO **shall** request a meeting with the practitioner. The CEO shall create a record of the meeting, and shall document that the practitioner was informed that the conduct in question was inappropriate. The CEO will also, during that meeting, review the substance of this policy with the practitioner, and explain to the practitioner the possible results of continued disruptive conduct. A follow-up letter to the practitioner shall state that the practitioner is required to behave professionally and cooperatively.

2. If there is a second incident of disruptive behavior, the CEO and Chief of Staff shall follow the same process as described above. However, this second meeting with the practitioner shall constitute the practitioner's final warning. A letter shall be sent to the practitioner following the meeting informing the practitioner that if there is a third incident of disruptive behavior, the matter will be referred to the hospital's Medical Executive Committee for appropriate corrective action, which may include a referral to the Board of Trustees for suspension from the medical staff, or termination of the practitioner's medical staff privileges.

3. If there is a pattern of disruptive behavior (defined as three or more incidents of disruptive behavior), the CEO and/or Chief of Staff shall refer the matter to the Medical Executive Committee for recommendation and to the Board of Trustees for final action and resolution of the matter. Any action, recommendation or communication by the MEC becomes a part of the practitioner's permanent file. More formal corrective action may be pursued at this juncture if deemed warranted by the Chief of Staff and/or CEO.

4. Nothing herein shall be deemed to prohibit more formal corrective action as a result of a single incident, or at any time during the investigative or corrective action process, should the Chief of Staff and/or the CEO determine that the seriousness of the incident justifies such action.

5. If at any time during the process any participant has reason to believe that the practitioner's behavior may result from an impairment, the procedures set forth in the Impaired Practitioner Policy should be followed.

6. Summary suspension may be appropriate pending the completion of this process, depending on the substance and seriousness of the reported offense. Any summary suspension pursuant to this policy must meet the requirements for summary suspension as outlined in the Medical Staff Bylaws.

Disciplinary Action Pursuant to Medical Staff Bylaws

1. The CEO and Chief of Staff shall be responsible for presenting the history of conduct to the Medical Executive Committee.

2. The Medical Executive Committee shall be fully apprized of any reports of disruptive conduct, and any meetings and warnings, so that it may pursue whatever action is necessary to terminate the unacceptable conduct.

3. The Medical Executive Committee may refer the matter to the Board of Trustees with or without recommendation as to action. If the Medical Executive Committee makes a recommendation, it shall be processed as provided in the corrective action section of the Medical Staff Bylaws.

4. Should the Medical Executive Committee forward the matter without a recommendation, any further action, including any hearing and appeal, shall then be initiated by the Board of Trustees and shall be processed as provided in the corrective action section of the Medical Staff Bylaws.

Although this policy is intended to outline a suggested method of progressive counseling and discipline, nothing herein shall be deemed to require such progressive discipline in the event that the seriousness of the individual's behavior warrants immediate corrective action. A single egregious incident, including but not limited to physical or sexual harassment, a felony conviction, assault, a fraudulent act, stealing, or damaging hospital property may result in immediate corrective action.

Documentation and Document Retention

1. All meetings with the practitioner and/or relating to the reported disruptive conduct shall be documented and maintained in the practitioner's quality credentials file.

2. After each meeting with the practitioner, a letter which summarizes the substance of the meeting shall be sent to the practitioner.

3. A copy of all original Reports shall be maintained in the practitioner's quality credentials file with all of the documents and notes on the matter. The practitioner may also submit a written response to be placed in the file if he/she so desires.

EXHIBIT A – Appendix "C" Disruptive Practitioner's Conduct

DISRUPTIVE PHYSICIAN BEHAVIOR
Privileged and Confidential for use by Legal Counsel
Not Part of the Medical Record
DO NOT PHOTOCOPY

Date Form Completed: _____

Section 1: General Information

Physician Involved: _____ Date of disruptive behavior: _____
Time of disruptive behavior: _____am / pm
Location of incident: _____
Were any patients involved in the incident? Patient chart number:_____
Names and description (employee, visitor, vendor, etc) of Witnesses, if any: _____
_____
_____

Section 2: Description of Disruptive Behavior

Describe the behavior you witnessed: _____
_____
_____
_____

Was patient care affected? If so, please describe what occurred _____
_____
_____
_____
_____

What actions, if any, did you or any other person take at the time of the incident: _____
_____
_____
_____
_____

Section 3: Verification of Report

Please sign below verifying that the contents of this report are true and accurate, to the best of your knowledge, and based on personal knowledge of the reported disruptive behavior. Once completed, this report should be delivered to the Hospital Chief Executive Officer.

Name of Person Reporting: _____ Signature: _____
_____

DISRUPTIVE PRACTITIONERS CONDUCT POLICY
APPROVED & ADOPTED:

MEDICAL STAFF:

By:_____ _____
Chief of Staff Date

BOARD OF MANAGERS:

By:_____ _____
Chairperson Date

GRACE MEDICAL CENTER

By:_____ _____
Chief Executive Officer Date