West Hospital

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Owner:	*Shannon Galloway: Supv-Credentialing*
Area:	*Medical Staff*
Tags:	
Applicability:	*Indiana University Health West Hospital*

Code of Conduct

I. PURPOSE

All individuals working at IU Health facilities ("Hospital") must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner. This policy is intended to address conduct which does not meet that standard. In dealing with incidents of inappropriate conduct, the protection of patients, employees, physician, and others in the hospital and the orderly operation of the hospital are paramount concerns. Complying with the laws and providing an environment free from sexual harassment are also critical. The IU Health West Medical Staff supports good patient care and strong morale and cannot tolerate behavior which is disruptive to this goal. This policy outlines collegial and education efforts that can be used by the respective Service Co-Chief, facility-based Chief Medical Officer, Medical Staff President, or a Medical Staff Officer in the event that the President of the Medical Staff is not available, and/or the Credentials Committee to address inappropriate conduct. 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 disciplinary process in the Bylaws, Rules and Regulations, and medical staff policies.

II. SCOPE

This policy applies to all physicians and licensed independent practitioners credentialed through the Medical Staff who provide patient care and services in IU Health facilities, including facilities leased from IU Health Partners.

III. EXCEPTIONS

None

IV. DEFINITIONS

None

V. POLICY STATEMENTS

A. To aid in both the education of the Medical Staff members and the enforcement of this policy, examples of "inappropriate conduct" include, but are not limited to:

   1. Threatening or abusive language directed at patients, visitors, nurses, hospital personnel, or other

physicians (e.g. belittling, berating, and/or threatening another individual);

2. Degrading or demeaning comments to or regarding patients, visitors, nurses, physicians, hospital personnel, or the hospital;
3. Profanity or similarly offensive language while in the hospital and/or while speaking with nurses, other hospital personnel, patient(s), or visitor(s);
4. Inappropriate physical contact with another individual that is threatening or intimidating;
5. Public derogatory comments including, but not limited to the quality of care being provided by the Hospital, another Medical Staff Member, or any other individual or otherwise critical of the Hospital, another Medical Staff member, or any other individual that are made outside of appropriate Medical Staff and/or administrative channels;
6. Inappropriate medical record entries including, but not limited to the quality of care being provided by the Hospital or any other individual or are critical of the Hospital, other Medical Staff members or personnel.
7. Refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Rules and Regulations, and Medical Staff Policies (including, but not limited to emergency call issues, response times, medical record keeping, other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively with other members of the Medical and Hospital Staffs);

B. "Sexual harassment" as 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:

1. **Verbal:** Innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;
2. **Visual/Non-Verbal**: Derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;
3. **Physical**: Unwanted physical contact, including touching, interference with an individual; normal work movement, and/or assault;
4. **Other**: Making or threatening retaliation as a result of an individual's negative response to harassing conduct.

Any complaint or allegation of inappropriate conduct against a medical staff practitioner will be handled by this policy, the MS 3.16 *Medical Staff Peer Review Policy*. Not all reported incidents of inappropriate conduct received will fall under the scope of this policy. The decision to implement the policy in a given case will be made through evaluation by the Medical Staff Office professional staff and review by representatives of the Quality & Peer Review Committee

C. 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 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 Medical Executive Committee or the elimination of any particular step in the Policy.

VI. PROCEDURES

A. **REPORTING OF INAPPROPRIATE CONDUCT:**

1. Hospital employees, residents, fellows, and medical staff who observe, or are subject to, inappropriate conduct by a medical staff member should notify the IU Health West Medical Staff Office via the "Complaint Reporting" link on the Pulse page in addition to speaking with his/her supervisor. If the inappropriate conduct is by the employee's supervisor who happens to be a Medical Staff member, the employee should notify the IU Health West Medical Staff Office and the facility Chief Medical Officer.
2. Upon learning of the occurrence of an incident of inappropriate conduct, the supervisor shall request that the individual who reported the incident to document it in writing or on the Complaint Reporting link. If he/she does not wish to report the matter, the supervisor should speak with the individual regarding their apprehension to report and collegially encourage the individual to complete the report. If he or she still does not wish to do so, the supervisor should submit the complaint report after trying to ascertain the refusal reasons. The submitted report should include the individual's reasons for declining to report.
3. The documentation should include:
    a. The date, time and location of the incident;
    b. A factual description of the questionable behavior;
    c. The name of any patient or patient's family member who was involved in the incident, including any patient or family member who 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;
    h. The name and contact information (phone number or email address) of the individual reporting the matter. If in a written format, a signature or the reporter must also be included.

B. **Process prior to Quality & Peer Review Committee:**

1. The appropriate professional personnel of the Medical Staff Services department will review the report and supporting documentation and may communicate with the individual(s) who prepared it; any witnesses to the event; or with the practitioner involved to obtain his/her side of the events.
2. Information from the physicians' quality file and Medical Staff quality database may be reviewed for historical information and tracking of data.
3. In the event that the complaint alleges physical hostility or verbal aggressiveness, a member of the Quality & Peer Review Committee may speak with the involved practitioner prior to a letter being generated. The collegial meeting will serve as the practitioner's notice of the complaint or concern received.
4. In cases that do not involve hostility or aggressiveness, information gathered if sufficient will be forwarded to a member of the Quality & Peer Review Committee for review.
5. The member of the Quality & Peer Review Committee, after review of the case, may decide to close

the case as unsubstantiated; have a collegial discussion with the practitioner; send an educational letter; choose to present the case to the Quality & Peer Review Committee for direction; or invite the practitioner to an upcoming Quality & Peer Review Committee. In the event the decision is made to review the case at the Quality & Peer Review Committee without an invitation to attend extended to the practitioner first, a letter will be sent to the practitioner informing him/her of the complaint/concern that offers him/her the opportunity to respond in writing within a reasonable time period as determined by the Co-Chair of the Quality & Peer Review Committee. Practitioner invitations to attend the Quality & Peer Review Committee will be communicated in writing and or email.

6. If a member of the Quality & Peer Review Committee deems the complaint to be retaliatory against a practitioner, then the reporter's supervisor will be notified.
7. If insufficient information is provided to properly investigate the report (i.e. no contact information; no identified physician information; or no name of the reporter and no witnesses; etc.) the report review will be closed until further time in which additional information is provided.
8. If the report is lacking in substance (for example: coffee stain left on a counter; phone book not returned to the correct location; etc.) the report review will be closed.

C. The identity of the individual reporting a complaint of inappropriate conduct will generally not be disclosed to the practitioner during these efforts, unless the facility Chief Medical Officer or President of the Medical Staff agree in advance that it is appropriate to do so.

D. The physician representative of the Quality & Peer Review Committee will provide a report to the Quality & Peer Review Committee of all incidents reviewed, interventions taken or recommendations for the practitioner to appear before the committee. The Quality & Peer Review Committee can accept the reviewer's recommendations or impose other interventions for the practitioner as outlined above.

E. If the Quality & Peer Review Committee prepares any documentation for a practitioner's file regarding its efforts to address concerns with the practitioner, the practitioner shall be apprised of that documentation and given an opportunity to respond in writing. Any such response shall then be kept in the practitioner's confidential file along with the original concern and the committee's documentation.

F. If additional complaints are received concerning a practitioner, the Quality & Peer Review Committee may continue to utilize the collegial and educational steps noted above, as long as it believes that there is still a reasonable likelihood that those efforts will resolve the concerns.

G. **Referral to the Medical Executive Committee**
At any point, the Quality & Peer Review Committee may refer the matter to the Medical Executive Committee (MEC) for review and action. The MEC shall be fully appraised of the actions taken by the Quality & Peer Review Committee to address the concerns. When it makes such a referral, the Quality & Peer Review Committee may also suggest a recommended course of action, including but not limited to:

1. Require the practitioner to meet with the Board chair;
2. Require the practitioner to meet with the MEC;
3. Issue a letter of warning or reprimand;
4. Require the practitioner to obtain a referral to the Indiana State Medical Association (ISMA) Physician Assistance Program for evaluation of and assistance with disruptive behavior;
5. 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
6. Suspend the practitioner's clinical privileges equal to or less than fourteen (14) calendar days.

The imposition of any of these actions does not entitle the practitioner to a hearing or appeal.

H. The MEC may take additional steps to address the concerns as well. 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 MS 3.16 Peer Review Policy.

VII. CROSS REFERENCE

MS 3.16 Peer Review

VIII. REFERENCES/CITATIONS

None

IX. FORMS/APPENDICES

None

X. RESPONSIBILITY

Medical Staff

XI. APPROVAL BODY

Medical Staff
IU Health West Board of Directors

XII. APPROVAL SIGNATURES

Approved by:

Date
Jason Ford, MD, Chair
Credentials Committee

Date
Darren Caudill, DO
Chair, Medical Executive Committee
President, IU Health West Medical Staff

Date
Chuck Schalliol
Chair, Board of Directors
IU Health West

XIII. DATES

Approval Date: February 2013
Effective Date: February 2013
Revision Date: May 2016

Revision Date: May 2019

Policy #:

MS 3.33

Attachments:

Approval Signatures

Step Description	Approver	Date
CMO/Director	Harpreetinder Singh: VP-CMO-West Hospital	09/2019
	Shannon Galloway: Supv-Credentialing	09/2019

Applicability

Indiana University Health West Hospital