SAINT JOSEPH
Regional Medical Center

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Title: MEDICAL STAFF MISSION STATEMENT AND CODE OF CONDUCT POLICY

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Location: Saint Joseph Regional Medical Center (SJRMC) - Mishawaka & Plymouth		Department: Medical Staff Services

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MEDICAL STAFF MISSION STATEMENT

The Medical Staff of SJRMC, Mishawaka and SJRMC, Plymouth are organized to promote the health of our community. The Medical Staff is committed to excellent patient care and embraces the highest standards of the profession in its relationship with patients, SJRMC associates and our peers.

MEDICAL STAFF CODE OF CONDUCT

A. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all Medical Staff members and Allied Health Professionals practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.
B. When a Medical Staff member or Allied Health Professional encounters circumstances suboptimal to the care of their patient it is their responsibility to document the occurrence by entering it into the Midas reporting system, or by reporting it to administrative personnel or by contacting the Medical Staff Office.
C. Medical Staff members and Allied Health Professionals will refrain from disruptive behavior as outlined in the policy statement below.
D. Medical Staff members and Allied Health Professionals will abide by the Bylaws, Rules and Regulation and Policy and Procedure manuals, which have been adopted by the Medical Staff.
E. Medical Staff members and Allied Health Professionals will follow mandated guidelines as defined by HIPAA, EMTALA and they shall refrain from conflicts of interest as defined by state and federal laws and regulations.
F. Medical Staff members and Allied Health Professionals will attend patients when called upon to do so without regard to ethnicity, gender or financial status as outlined in anti-discrimination law.
G. Medical Staff members and Allied Health Professionals will agree to provide consulting service within the practitioner's defined area of expertise when called upon to do so without regard to ethnicity, gender or financial status according to Medical Staff Bylaws 2A3c.
H. Medical Staff members and Allied Health Professionals shall participate in peer review, quality improvement and assigned committees as requested by his/her department chairperson or other medical staff leaders.
I. Medical Staff members and Allied Health Professionals shall bring concerns regarding peer behavior to the attention of the medical staff leadership in order to promote timely investigation and when appropriate collegial intervention. The principle of confidentiality and patient safety are paramount concerns governing this reporting.

POLICY:

It is the policy of the Medical Staff, which includes physicians and allied health professionals ("Practitioner") that all individuals within SJRMC facilities be treated with courtesy, respect, and dignity. To that end, all Practitioners shall conduct themselves in a professional and cooperative manner in the hospital.

If a Practitioner fails to conduct him or herself appropriately, the matter shall be addressed in accordance with the following policy.

1. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all Practitioners practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.
2. A Practitioner, treating patients at SJRMC-Mishawaka and SJRMC-Plymouth, may encounter circumstances suboptimal to the care of their patient. This may occur from deficiencies in supplies or equipment or from deficiencies in hospital personnel working on their behalf. Hospital policies and procedures will require upgrades from time to time with changes in medical knowledge. The Practitioner is encouraged to document perceived substandard care and to work towards possible solutions. This should occur in a constructive manner. The SJRMC Midas reporting system allows for appropriate documentation of such events and a means by which they can be analyzed by hospital personnel. The system is intended to promote useful dialogue and a platform for problem solving, ultimately resulting in improved patient care. Documenting an occurrence can be accomplished by:
   A. Document in writing the date, description, patient name, witnesses (if any) of any occurrence and submit this documentation to one of the following individuals. (See attached form)
      1) Medical Staff President - 335-2353
      2) VP Quality Improvement - 335-1035
      3) Medical Staff Office, Mishawaka– 335-2383
      4) Medical Staff Office, Plymouth – 948-5005
   B. or, enter an occurrence directly into Midas:
      1) Go to Daily Dose
      2) Click on Favorites
      3) Go to SJRMC Websites and Click on Midas RDE
      4) Click on Risk
      5) Select the Appropriate Risk Form depending on occurrence
      6) Select the correct Facility – Mishawaka or Plymouth.
      7) Enter incident date
      8) Choose patient or non-patient incident and click Next (the next screens vary based on patient or non-patient)
      9) Patient:
         a) Enter patients medical record number or name
         b) Choose incident type by clicking on the drop down arrow to the right
         c) Enter factors contributing to incidence by clicking on magnifying glass and select the factor(s) from the right side of the screen – then click OK
         d) Enter where the incident took place by clicking on the magnifying glass and select unit from the menu at the right side of the screen – then click OK
         e) Enter shift – Also enter time and room if information is available
         f) Enter your last name and hit tab – select your first name if multiple options

g) Enter narrative of incident
h) Click Save

10) Non-Patient:
a) Choose incident type by clicking on the drop down arrow to the right
b) Enter factors contributing to incidence
c) Enter where the incident took place
d) Enter shift – also enter time and room if information is available
e) Enter non-patient type by clicking on magnifying glass and select type from the right side of the screen
f) Enter non-patient name
g) Complete "entered by" by entering your last name and hit tab – select your first name if multiple options
h) Enter narrative of incident
i) Click Save

C. You can also document the above by calling the Physician Concern Line at 285-5899 (Mishawaka only) and leave the details including the date, description, patient name, witnesses (if any) of any occurrence and a Midas entry will be made on your behalf.

3. This Policy outlines collegial and educational efforts that can be used by the SJRMC-Mishawaka and SJRMC-Plymouth Medical Staff 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 Credentials Policy.
4. This Policy also addresses issue of alleged sexual harassment of employees, patients, other Practitioners of the Medical Staff, and others, which will not be tolerated.
5. 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 in which the highest ethical and professional standards are maintained.
6. All efforts undertaken pursuant to this Policy shall be part of the Hospital's performance improvement and professional and peer review activities.
7. If there is a possibility of an impairment issue, the Medical Staff Impaired and Dysfunctional Physician Policy should be referenced and consideration of referring the physician/practitioner to the Medical Staff Well-Being Committee should take place.
8. Reports shall be kept in the peer review protected practitioner's confidential file. These confidential files are retained in the Medical Staff Office.

GUIDELINES

A. A single egregious incident or repeated incidents shall initiate an investigation. Summary suspension may be appropriate pending this process. If it is unclear whether the conduct was actually disruptive, the Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth)

or President of the Hospital (Plymouth) may seek the expert opinion of an impartial individual experienced in such matters.

1) 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 or Allied Health Professionals will be addressed in accordance with this Policy.
2) Every effort will be made to coordinate the actions contemplated in this Policy with the provisions of the Credentials Policy. In the event of any apparent or actual conflict between this Policy and the Credentials Policy, the provisions of this Policy shall control.
3) 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 as determined by an appropriate investigation 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 Executive Committee or the elimination of any particular step in the Policy.
4) Except as otherwise may be determined by the Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth), the practitioner's counsel shall not attend any of the meetings described in this Policy.
5) The Medical Staff leadership and Hospital Administration shall make employees, Practitioners 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.

B. Unacceptable 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, or patients, that are personal, irrelevant, or beyond the bounds of fair professional conduct.
2) degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;
3) profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;
4) inappropriate physical contact with another individual that is threatening or intimidating;
5) unfocused non-constructive derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff and/or administrative channels;
6) inappropriate medical record entries impugning the quality of care being provided by the Hospital, Medical Staff Practitioner or any other individual;
7) imposing onerous requirements on the nursing staff or other Hospital employees;
8) refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentials Policy, and Rules and Regulations (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 Practitioners of the Medical and Hospital Staffs); and/or

9) "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: innuendoes, 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.

REPORTING OF INAPPROPRIATE CONDUCT

A. 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 shall include:
   1) Practitioners, nurses and other Hospital employees who observe, or are subjected to, inappropriate conduct by another Practitioner shall:
      a) notify the practitioner about the incident or,
      b) notify their supervisor about the incident or, if their supervisor's behavior is at issue,
      c) shall notify the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth).
   2) Any practitioner who observes such behavior by another practitioner is encouraged notify the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) directly.
   3) The individual who reports an incident shall be requested to document it in writing. If he or she does not wish to do so, the supervisor or Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) may document it, after attempting to ascertain the individual's reasons for declining and encouraging the individual to do so.
   4) 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.

5) Any physician or employee may report potentially disruptive conduct. The report shall be submitted to the medical director or a facility administrator and then forwarded to the Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) for further consideration and or investigation as indicated.

INVESTIGATION

A. All reports of questionable behavior are fully investigated by risk management and medical staff services on behalf of the medical staff who may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident prior to any discussion with physician/practitioner. Once an incident is confirmed, a report will be forwarded to the Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth). Unconfirmed reports will be dismissed in which case the individual initiating such report will be apprised.

B. If there is a possibility of an impairment issue, the Medical Staff Impaired and Dysfunctional Physician Policy should be referenced and consideration of a self-referral or referral of the physician/practitioner to the Medical Staff Well Being Committee should take place.

C. If an incident of inappropriate conduct has likely occurred, then the Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) is informed and investigation will be conducted by medical staff leadership. Medical staff leadership has several options available, including, but not limited to, the following:

   1) notify the practitioner and Department Chairperson that a complaint has been received and invite the practitioner to meet with the Department Chairperson, the Medical Staff President and if necessary the Chief Medical Officer of the Hospital (Mishawaka & Plymouth) or President (Plymouth) to discuss it in a collegial manner;

   2) send the practitioner a letter of guidance about the incident;

   3) 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;

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

   5) all meetings will take place within 30 days of the date the report was received and verified and will be documented with and a copy placed in the physician's medical staff file;

D. During an investigation the identity of an individual reporting a complaint of inappropriate conduct will not be disclosed to the practitioner. 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 Executive Committee pursuant to the Credentials Policy.

E. If the Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) 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 Chief Operating Officer of the Hospital and/or the President of the Medical Staff documentation.

F. If additional complaints are received concerning a practitioner, the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) 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.

ACTION

A. A single confirmed incident warrants a discussion with the offending physician; the medical staff leadership designee shall initiate such a discussion and emphasize that such conduct is inappropriate and must cease. The initial approach should be collegial and helpful to the physician/practitioner and the hospital.

B. If it appears that a pattern of disruptive behavior is developing, the medical staff leadership and the Chief Medical Officer of the Hospital (Mishawaka & Plymouth) or President (Plymouth) or their designee shall discuss the matter with the physician/practitioner as outlined below:

   1) Emphasize that if such repeated behavior continues, more formal action will be taken to stop it. The MEC and CEO will be notified.

   2) All meetings will take place within 30 days of the date the report was received and verified and will be documented with a copy placed in the physician's medical staff file;

   3) A follow-up letter to the physician/practitioner shall state the nature of the problem and inform the individual that he or she is required to behave professionally and cooperatively within the hospital.

   4) The involved physician/practitioner may submit a rebuttal to the charge. Such rebuttal will be maintained as a permanent part of the record.

C. The presence of an attorney for the practitioner or the Hospital is allowed only after an investigation has been fully reviewed and a determination has been made in which the practitioner is entitled to a Hearing. i.e. suspension of privileges for longer than 30 days, revocation of membership or privileges, etc.

Referral to the Executive Committee

A. At any point, the Chief Medical Officer of the hospital (Mishawaka & Plymouth) or President of the Hospital (Plymouth) and/or medical staff leadership may refer the matter to the Executive Committee for review and action. The Executive Committee shall be fully apprised of the actions taken by the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) or others to address the concerns.

B. If the Medical Executive Committee, after review of information provided, calls for an investigation then the matter is referred to the Credentials Committee, which becomes the investigative body of the medical staff. The Credentials Committee then issues a report to the Medical Executive Committee of its finding. The Medical Executive Committee may, based upon the facts and recommendations presented by the Credentials Committee, make recommendations for action including, but not limited to, the following:

   1) require the practitioner to meet with the Board Chair;

   2) require the practitioner to meet with the full Executive Committee;

   3) issue of a letter of warning or reprimand;

   4) require the practitioner to obtain a psychiatric evaluation by a physician chosen by the Executive Committee;

5) require the physician to complete a behavior modification course;
6) 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
7) 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.

C. At any point, the Medical Executive Committee may also make a recommendation regarding the practitioner's continued appointment and clinical privileges including, but not limited to, revocation and/or suspension for greater than 30 days 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.

Sexual Harassment Concerns

A. Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:
   1) A meeting shall be held with the Practitioner to discuss the incident. All meetings will take place within 30 days of the date the report was received and verified and will be documented with and a copy placed in the physician's medical staff file. 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 quality 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 Executive Committee for review pursuant to the Credentials 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 Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth), or 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 Credentials Policy, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.

This policy shall be the sole process for dealing with egregious incidents and disruptive behavior, and shall be interpreted and enforced by the Medical Staff.

Attachment: Documentation Form
Retaliation and Retribution Hospital Policy

PRACTITIONER USE – DOCUMENTATION OF OCCURRENCE

Date of Occurrence:	
Date of this Report:	
Patient Name/Medical Record Number: (if known)	
Description of Occurrence:	
Witnesses: (if any)	
Name of Practitioner Making Report:	

Submit this form to one of the following:

- Medical Staff President- Mishawaka
  Ph: 335-2353
  Fax: 335-1001
- Medical Staff Office – Mishawaka
  Ph: 335-2383
  Fax: 335-1053
  Plymouth
  Ph: 948-5005
  Fax: 948-5478

References/Standards:

- Policy Origin Date: May 1999
- Review Date: December 2009(M), December 2012 (M), December 2015 (M), February 2016 (P), December 2018 (M)
- Revised Date: August 2007 (M), January 2012 (P)
- Effective Date: December 1999 (M), December 1999 (P)
- Reviewed/Recommended By: Medical Executive Committee
- Policy 154

TITLE: RETALIATION AND RETRIBUTION

POLICY:

1. All employees, supervisors, physicians and trustees have a responsibility to report in good faith, concerns about actual or potential wrongdoing and are not permitted to overlook such situations. We are firmly committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against an employee, physician, trustee or volunteer for making a good faith report of their concerns.
2. No one at any level of SJRMC is permitted to engage in retaliation or any form of harassment against an employee, physician, trustee or volunteer reporting a concern. Anyone who engages in such retribution is subject to discipline, up to and including dismissal on the first offense. All substantive instances of retaliation or harassment against anyone reporting through the Four-Step Process will be brought to the attention of the Organizational Integrity Officer.
3. This does not mean that employees or others will be shielded from the consequences of doing something wrong simply by reporting their actions or from the consequences of their actions under current employment policies. However, a prompt and forthright disclosure, even if the error was willful, may be considered a constructive action.

References/Standards:

- Policy Origin Date: June 1998
- Review Date: September 2005, December 2012 (M), December 2015 (M), February 2016 (P), December 2018 (M)
- Revised Date:
- Effective Date: April 2009
- Reviewed/Recommended By: Organizational Integrity Team