MEMORIAL HEALTH

JACKSONVILLE MEMORIAL HOSPITAL

MEDICAL STAFF PROFESSIONALISM POLICY

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MEDICAL STAFF
PROFESSIONALISM POLICY

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MEDICAL STAFF
PROFESSIONALISM POLICY

1. POLICY

(a) Collegiality, collaboration, and professionalism are essential for the provision of safe and competent patient care. Unprofessional Conduct (as defined in Section 10.N of this Policy) is inconsistent with a culture of quality care and safety. Accordingly, all Practitioners at Jacksonville Memorial Hospital (the "Hospital") must treat others with respect, courtesy, and dignity, and must conduct themselves in a professional and cooperative manner.

(b) This Policy outlines the process that will be used to evaluate and collegially resolve concerns that a Practitioner has engaged in Unprofessional Conduct. A flowchart that outlines the review process is in Appendix A.

2. REPORTS OF UNPROFESSIONAL CONDUCT

2.A ***Reports.***

(1) Hospital employees or Practitioners who observe, or are subjected to, Unprofessional Conduct by a Practitioner shall report the incident in a timely manner by submitting a completed Professional Conduct Reporting Form to the PPE Specialists or through some other approved Hospital reporting mechanism. A Professional Conduct Reporting Form is included as PM-1 in the Professionalism Manual.

(2) Any individual receiving such a report will forward it to the PPE Specialists.

(3) The PPE Specialists may use a screening process approved by the Leadership Council to confirm that a reported concern involves unprofessional conduct. The PPE Specialists will provide periodic aggregate reports to the Leadership Council of the results of any such screening process. If a report is found to not involve unprofessional conduct by a Practitioner, documentation of the report will be not be maintained in the Practitioner's confidential file.

(4) The PPE Specialists shall notify the Medical Staff President, relevant Department Chair and Chief Medical Officer ("CMO") of reported concerns that are believed to involve Unprofessional Conduct by a Practitioner and log the report in a confidential peer review database.

2.B ***Follow-up with Individual Who Filed Report.*** The PPE Specialists or CMO shall follow up with individuals who file a report. A Response to Individual Who

Reported Concerns About Conduct is included as PM-2 in the Professionalism Manual.

2.C ***Directing Review of Reports.*** As members of the Leadership Council, the Medical Staff President and CMO are authorized to direct the review of each specific report of Unprofessional Conduct as outlined in this Policy.

3. RESOLUTION OF MINOR CONCERNS

3.A ***Dismissal of Reported Concerns Not Involving Unprofessional Conduct.*** The Medical Staff President or Department Chair, in conjunction with the CMO, may determine that a reported concern does not involve unprofessional conduct by a Practitioner and may be dismissed altogether (in which case documentation of the reported concern will not be maintained in the Practitioner's confidential file).

3.B ***Criteria for Resolution of Minor Concerns.*** A reported concern may be resolved without the need for further review under this Policy if the Medical Staff President or the Department Chair, in conjunction with the CMO, determine that: (1) the reported concern is minor in nature; and (2) there is no history or pattern with the Practitioner in question.

3.C ***Procedure for Resolution of Minor Concerns.***

(1) For concerns that qualify as minor, the Medical Staff President, Department Chair or CMO will communicate with the Practitioner about the matter (e.g., via a brief conversation or note). The purpose of this communication is to make the Practitioner aware that another individual perceived the Practitioner's behavior as unprofessional so that the Practitioner may reflect and self-correct as needed. No conclusions about the Practitioner's behavior are reached as a result of this process, so there is no need for fact-finding or input from the Practitioner. The individual who communicates with the Practitioner may choose to follow up with a brief note to the Practitioner memorializing any conversation.

(2) The Medical Staff President or CMO will notify the PPE Specialists that a minor concern has been resolved in this manner. A Form to Document Resolution of Minor Concerns is included as PM-3 in the Professionalism Manual.

3.D ***Reports to Leadership Council.*** The PPE Specialists will provide the Leadership Council with periodic reports of minor concerns that have been resolved under this section to allow for oversight of the process and consistency.

4. PROCEDURE WHEN CONCERNS ARE MORE SIGNIFICANT OR A PATTERN HAS DEVELOPED

The steps set forth below apply to reported concerns about behavior that, as determined by the Medical Staff President or Department Chair, in conjunction with the CMO, involve: (1) more serious allegations; or (2) a pattern of behavior.

4.A ***Preliminary Notification to Practitioner.*** The Medical Staff President, Department Chair, or CMO should notify the Practitioner that a concern has been raised and that the matter is being reviewed. Generally, this preliminary communication should occur via a brief telephone call or a personal discussion as soon as practical. The Practitioner should be informed that he or she will be invited to provide input regarding the matter after further review of the reported concern has occurred and before any review by the Leadership Council. The Practitioner should also be reminded to avoid any action that could be perceived as retaliation (including any attempt to discuss the matter with an individual who the Practitioner believes may have raised the concern or provided information about it). PM-4 and PM-5 in the Professionalism Manual include an Instructions and Script and a Form to Document Preliminary Notification to Practitioner When Concerns Are More Significant or a Pattern Has Developed.

4.B ***Notification to Employer.*** If a reported concern involves an Employed Practitioner, the PPE Specialists will notify the Employer that the matter is being reviewed pursuant to this Policy. The Employer will be invited to provide any information that it believes may be relevant to the Employed Practitioner and the concern being reviewed. The Employer will also be informed that the Leadership Council may request the Employer's participation in the review.

4.C ***Fact-Finding.*** The Medical Staff President, Department Chair and/or CMO, acting on behalf of the Leadership Council, shall in their discretion interview witnesses or others who were involved in the incident and gather any other necessary documentation or information (e.g., interviews with core leaders or nurse/area leaders) needed to assess the reported concern. These individuals may also direct the PPE Specialists to perform these functions. An Interview Tool for Fact-Finding: Script, Questions and Guidance that may be used for such interviews is included as PM-6 in the Professionalism Manual. Such fact-finding is conducted at the direction of and on behalf of the Leadership Council. Any records created are records of the Leadership Council.

4.D ***Determination by Medical Staff President/Department Chair and CMO.***

(1) ***No Further Review Required.*** Following the interviews and fact-finding, the Medical Staff President or Department Chair, in conjunction with the CMO, may determine that a reported concern does not raise issues that need to be addressed pursuant to this Policy. In such case, no input regarding the circumstances will be sought from the Practitioner, the matter will be

closed, and the Practitioner and Leadership Council will be notified of this determination.

(2) ***Further Review Required.*** The Medical Staff President or Department Chair, in conjunction with the CMO, may determine that a matter should be reviewed further by the Leadership Council. In such case, the Practitioner's input and perspective will be obtained on behalf of the Leadership Council as set forth in Section 5 of this Policy. The matter shall then be referred to the Leadership Council. The PPE Specialists shall prepare a summary report of the matter for review by the Leadership Council and provide the Leadership Council with all supporting documentation.

5. OBTAINING INPUT FROM THE PRACTITIONER

5.A ***General.*** The Medical Staff President, CMO, or Leadership Council will provide details of the concern (but not a copy of any reported concern) to the Practitioner and ask the Practitioner to provide a written explanation of what occurred and his or her perspective on the incident. A Cover Letter to Practitioner Seeking Input Regarding Behavior Concern which may be used for this purpose is included as PM-7 in the Professionalism Manual.

5.B ***Sharing Identity of Any Individual Reporting a Concern.*** Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter (the "reporter") will not be disclosed to the Practitioner unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.

5.C ***Reminder of Practitioner's Obligations.*** The Medical Staff President, CMO, or Leadership Council should remind the Practitioner of the need to maintain confidentiality and the importance of avoiding any actions that could be viewed as retaliation as part of seeking his or her input. The Cover Letter to Practitioner Seeking Input Regarding Behavior Concern set forth as PM-7 in the Professionalism Manual addresses these issues. If concerns about confidentiality and non-retaliation are more significant, the Practitioner may be required to sign a Confidentiality and Non-Retaliation Agreement (a copy of which is included as PM-8 in the Professionalism Manual) prior to providing detailed information regarding the concern to the Practitioner.

5.D ***Failure of the Practitioner to Provide Requested Input or Attend Meeting.***

(1) ***Automatic Relinquishment for Failure to Provide Written Input or Attend Meeting.*** A Practitioner's failure to provide written input or attend a meeting when requested to do so pursuant to this Policy will result in the automatic relinquishment of the Practitioner's clinical privileges, but only if all of the following conditions are satisfied:

(a) the Practitioner is asked in writing to provide written input to, or attend a meeting with, the Medical Staff President, Department Chair, CMO, or the Leadership Council;

(b) the written request gives the Practitioner a reasonable amount of time (generally five days) to provide the written input or to prepare for the meeting; and

(c) the written request notifies the Practitioner that failure to provide the written input or attend the meeting will result in the automatic relinquishment of clinical privileges pursuant to this Policy.

The Cover Letter to Practitioner Seeking Input Regarding Behavior Concern set forth as PM-7 in the Professionalism Manual satisfies these requirements. A Notice of Automatic Relinquishment that may be used if a Practitioner does not provide the requested input or attend a meeting is included as PM-9 in the Professionalism Manual.

(2) ***Hearing Regarding Automatic Relinquishment.*** A Practitioner who is the subject of an automatic relinquishment of clinical privileges may request a hearing with the Medical Executive Committee as set forth in the Medical Staff Bylaws.

(3) ***When Temporary Automatic Relinquishment Becomes Automatic Resignation from Staff.*** If a Practitioner automatically relinquishes clinical privileges pursuant to this Policy and fails to provide the requested written input or meet with the applicable individuals or committee within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned. A Notice of Automatic Resignation that may be used for this purpose is included as PM-10 in the Professionalism Manual.

(4) ***Automatic Relinquishment and Automatic Resignation Not Reportable.*** The automatic relinquishment or resignation of appointment and/or clinical privileges described in this Section are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency.

6. LEADERSHIP COUNCIL PROCEDURE

6.A ***Initial Review.*** The Leadership Council shall review the summary prepared by the PPE Specialists and all supporting documentation, including the response from the Practitioner. If necessary, the Leadership Council may also meet with the individual who submitted the report and any witnesses to the incident. The

Leadership Council may consult with or include in the review the Department Chair, another Medical Staff Leader, or any other individual who would be helpful to the review.

6.B ***Meeting Between Practitioner and Leadership Council.*** If either the Leadership Council or the Practitioner believes that it would be helpful prior to the Leadership Council concluding its review and making a determination, a meeting may be held between the Practitioner and the Leadership Council to discuss the circumstances further and obtain more facts. In its discretion, the Leadership Council may designate one or more committee members to attend the meeting rather than the full committee, regardless of who requested the meeting. The Leadership Council may also obtain additional written input from the Practitioner as set forth in Section 5 of this Policy.

6.C ***Refusal to Provide Information or Meet with Leadership Council.*** A Practitioner who refuses to provide information or meet with the Leadership Council will be deemed to have automatically relinquished his or her clinical privileges as set forth in Section 5 of this Policy.

6.D ***Employer Participation in Review.*** If a matter involves an Employed Practitioner, the Leadership Council may invite a representative of the Employer to attend relevant portions of committee meetings involving the Practitioner and participate in any interventions that may be conducted by the Leadership Council following the review. The chair of the Leadership Council has the discretion to recuse the Employer representative during any deliberations or vote on a matter.

6.E ***Leadership Council Determination.***

(1) ***Options.*** After its review of all relevant information, including input from the Practitioner, the Leadership Council may:

(a) determine that no further review or action is required;

(b) send the Practitioner an Educational Letter, providing guidance and counsel;

(c) engage in Collegial Counseling with the Practitioner and provide education and coaching (a Collegial Counseling Checklist and Follow-Up Letter to Collegial Counseling are included as PM-11 and PM-12 in the Professionalism Manual, respectively);

(d) develop a Voluntary Enhancement Plan for Conduct ("VEP"), as described in Section 7 of this Policy (an Implementation Issues Checklist for VEPs for Conduct is included as PM-13 in the Professionalism Manual);

(e) refer the matter to the Medical Executive Committee; or

(f) after consultation with the Employer, refer the matter to the Employer for disposition, with a report back to the Leadership Council regarding the action taken by the Employer. If the Leadership Council determines the Employer's action is insufficient, the Leadership Council may also make one of the other determinations set forth in this subsection.

(2) ***Leadership Council Review Not an Investigation.*** A review conducted by the Leadership Council or by any individual pursuant to this Policy shall not constitute an Investigation. As set forth in the Medical Staff Organization Manual, the Leadership Council possesses no disciplinary authority and only the Medical Executive Committee has the authority to commence a formal Investigation.

6.F ***Additional Reports of Unprofessional Conduct.*** If additional reports of Unprofessional Conduct are received concerning a Practitioner, the Leadership Council may continue to use the collegial and progressive steps outlined in this Policy as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

6.G ***Determination to Address Concerns through Practitioner Health Policy.*** The Leadership Council may determine to address the conduct concerns through the Practitioner Health Policy if it believes that there may be a legitimate, underlying health issue that is causing the concerns and the review process outlined in the Practitioner Health Policy is more likely to successfully resolve the concerns.

7. VOLUNTARY ENHANCEMENT PLANS FOR CONDUCT

7.A ***General.*** The Leadership Council may determine it is necessary to develop a Voluntary Enhancement Plan ("VEP") for the Practitioner. One or more members of the Leadership Council should personally discuss the VEP with the Practitioner to help ensure a shared and clear understanding of the elements of the VEP. The VEP will also be presented in writing, with a copy being placed in the Practitioner's file, along with any statement the Practitioner would like to offer.

7.B ***Voluntary Nature of VEPs.*** If a Practitioner agrees to participate in a VEP developed by the Leadership Council, such agreement will be documented in writing. If a Practitioner disagrees with a recommended VEP developed by the Leadership Council, the Practitioner is under no obligation to participate in it. In such case, the Leadership Council cannot compel the Practitioner to agree with the VEP. Instead, the Leadership Council will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Bylaws.

7.C ***VEP Options.*** A VEP for conduct may include, but is not limited to, one or more of the actions in this Section. None of these actions entitles the Practitioner to a hearing or appeal as described in the Medical Staff Bylaws, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank. A Voluntary Enhancement Plan Options ("VEP") for Conduct – Implementation Issues Checklist that may be used to assist with implementation of the following VEP options is included as PM-13 in the Professionalism Manual.

(1) ***Meeting with Designated Group to Conduct Enhanced Collegial Counseling.*** The Practitioner may be invited to meet with a designated group (such as a Medical Staff committee or an ad hoc group) to discuss the concerns with the Practitioner's conduct and the need to modify the conduct. An ad hoc group may include any combination of current or past Medical Staff Leaders, Hospital leaders, outside consultants, and/or the Board Chair or other Board members if the Leadership Council determines that Board member involvement is reasonably likely to impress upon the Practitioner involved the seriousness of the matter and the necessity for the Practitioner's conduct to improve. A letter outlining the discussion and expectations for conduct shall be sent to the Practitioner after the meeting;

(2) ***Periodic Meetings with Medical Staff Leaders or Mentors.*** The Leadership Council may recommend that the Practitioner be required to meet periodically with one or more Medical Staff Leaders or a mentor designated by the Leadership Council. The purpose of these meetings is to provide input and updates on the Practitioner's performance, as well as to offer assistance and support with any challenging issues the Practitioner may be encountering;

(3) ***Review of Literature Concerning the Connection Between Behavior and Patient Safety.*** The Leadership Council may recommend that the Practitioner review selected literature concerning the established connection between behavior and patient care and safety and then provide a report to the Leadership Council summarizing the information reviewed and how it can be applied to the individual's practice;

(4) ***Behavior Modification Course.*** The Leadership Council may recommend that the Practitioner complete a behavior modification course that is acceptable to the Leadership Council. The cost of this external assistance shall be borne by the Practitioner, unless the Leadership Council determines otherwise;

(5) ***Personal Code of Conduct.*** The Leadership Council may develop a "personal" code of conduct for the Practitioner, which provides specific guidance regarding the expectations for future conduct and outlines the specific consequences of the Practitioner's failure to abide by it; and/or

(6) ***Other.*** Elements not specifically listed above may be included in a VEP. The Leadership Council has wide latitude to tailor VEPs to the specific concerns identified, always with the objective of helping the Practitioner to improve his or her performance and to protect patients and staff.

8. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

8.A ***Referral to the Medical Executive Committee.*** At any point, the Leadership Council may refer the matter to the Medical Executive Committee for review and action because:

(1) the Practitioner refuses to participate in a Voluntary Enhancement Plan developed by the Leadership Council;

(2) the Voluntary Enhancement Plan options for conduct were unsuccessful; or

(3) the Leadership Council otherwise determines that Medical Executive Committee review is required.

The Medical Executive Committee shall be fully apprised of the actions taken previously by the Leadership Council to address the concerns. When it makes such a referral, the Leadership Council may also suggest a recommended course of action.

8.B ***Medical Executive Committee Review.*** The Medical Executive Committee shall review the matter and take appropriate action in accordance with the Medical Staff Bylaws. These actions include, but are not limited to, Collegial Counseling efforts, development of a Voluntary Enhancement Plan, commencement of an Investigation, a short-term suspension, a long-term suspension, and/or a recommendation to revoke appointment and clinical privileges, subject to any procedural rights as set forth in the Medical Staff Bylaws.

9. REVIEW OF REPORTS OF SEXUAL HARASSMENT AND OTHER IDENTITY-BASED HARASSMENT

9.A ***Definition.*** Sexual Harassment and other Identity-Based Harassment is defined in Section 10 of this Policy.

9.B ***Review Process for Sexual Harassment and Other Identity-Based Harassment Concerns and Agreements to Voluntarily Refrain from Clinical Activities During Review.*** All reports of potential Sexual Harassment and other Identity-Based Harassment will be reviewed by the Leadership Council in the same manner as set forth above. In addition, while a Practitioner may be asked to voluntarily refrain from exercising clinical privileges pending the review of any behavioral matter under this Policy, particular attention will be paid to whether it is necessary to

utilize such a temporizing safeguard while an allegation of Sexual Harassment or other Identity-Based Harassment is being reviewed.

9.C ***Personal Meeting and Letter of Admonition and Warning.*** Because of the unique legal implications surrounding Sexual Harassment and other Identity-Based Harassment, a single confirmed incident requires the actions set forth in this Section 9.C. Two or more members of the Leadership Council shall personally meet with the Practitioner to discuss the incident. If the Practitioner acknowledges the seriousness of the matter and agrees that there will be no repeat of such conduct, the meeting shall be followed with a formal letter of admonition and warning to be placed in the Practitioner's confidential file. This letter shall also set forth any additional actions or conditions imposed on the Practitioner's continued practice in the Hospital as a result of the meeting.

9.D ***Voluntary Enhancement Plan.*** In addition to the letter of admonition and warning, concerns about Sexual Harassment and other Identity-Based Harassment may also be addressed by a Voluntary Enhancement Plan for conduct as described in this Policy.

9.E ***Referral to Medical Executive Committee.*** The matter shall be immediately referred to the Medical Executive Committee if:

(1) the Practitioner refuses to acknowledge the concern, does not recognize the seriousness of it, or will not agree that there will be no repeat of such conduct;

(2) there are confirmed reports of retaliation or further incidents of Sexual Harassment or other Identity-Based Harassment, after the Practitioner agreed there would be no further such conduct; or

(3) the Leadership Council otherwise determines that Medical Executive Committee review is appropriate under the circumstances.

The Medical Executive Committee shall conduct its review in accordance with the Medical Staff Bylaws. Such referral shall not preclude other action under applicable Human Resources policies.

10. ADDITIONAL PROVISIONS GOVERNING THE PROFESSIONALISM REVIEW PROCESS

10.A ***Confidentiality.*** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

(1) ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents

(whether paper or electronic) should be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under Illinois or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

(2) ***Verbal Communications.*** Telephone and in-person conversations should take place in private at appropriate times and locations to minimize the risk of a breach of confidentiality (e.g., conversations should not be held in Hospital hallways).

(3) ***E-mail.*** Hospital e-mail may be used to communicate between individuals participating in the professionalism review process, including with the Practitioner in question. All e-mails should include a standard convention, such as "Confidential PPE/Peer Review Communication," in the subject line. E-mail should not be sent to non-hospital accounts unless the e-mail merely directs recipients to check their Hospital e-mail.

(4) ***Participants in the Review Process.*** All individuals involved in the review process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement. A Confidentiality Agreement – Medical Staff Leader and Confidentiality Agreement – Hospital Employee are included as PM-14 and PM-15, respectively, in the Professionalism Manual. Any breaches of confidentiality will be reviewed under this Medical Staff Professionalism Policy. Breaches of confidentiality by Hospital employees will be referred to human resources.

(5) ***Practitioner Under Review.*** The Practitioner under review must maintain all information related to the review in a strictly confidential manner. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in the Professionalism Policy without first obtaining the permission of the Leadership Council, except for any legal counsel who may be advising the Practitioner. Violations of this provision will be reviewed under the Professionalism Policy.

10.B ***Communications with Practitioner That Include a Deadline.*** Before any paper or electronic correspondence that includes a deadline for a response (for example, a request for input or to attend a meeting) is mailed or e-mailed to a Practitioner, a text message should be sent or a phone call should be made (or voice mail left) to alert the Practitioner that the correspondence is being sent. The intent of any such text message or phone call is to make the Practitioner aware of the correspondence so that the deadline is not missed. However, failure to send a text message or make a phone call shall not be cause for the Practitioner to miss a deadline.

10.C ***Immediate Referrals to Medical Executive Committee.*** This Policy outlines collegial and progressive steps (e.g., counseling, warnings, meetings, and behavior modification education) that can be taken to address concerns about Unprofessional Conduct by Practitioners. However, a single incident of Unprofessional Conduct or a pattern of Unprofessional Conduct may be of such concern that more significant 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 this Policy.

10.D ***Coordination with Other Policies That Govern Professional Conduct.*** If a report of unprofessional behavior involves an issue that is also governed by another Hospital policy that governs professional conduct (including, but not limited to, alleged violations of the Hospital's HIPAA or corporate compliance policies by a Practitioner), the Medical Staff President or CMO will notify the person or committee responsible for that other policy of the substance of the report. Efforts will be made to coordinate the review that occurs under this Policy with the review under such other policy. For example, individuals responsible for such other policies (such as the Hospital's HIPAA Privacy Officer or Corporate Compliance Officer) may be invited to take part in the witness interviews described in the Professionalism Policy or may discuss the matter with the Leadership Council or its representatives.

10.E ***No Legal Counsel or Recordings During Collegial Meetings.***

(1) To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings. In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

(2) Practitioners may not create an audio or video recording of a meeting. If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, Medical Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room. In exceptional circumstances, Medical Staff Leaders or Hospital personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

10.F ***Education Regarding Appropriate Professional Behavior.*** Medical Staff and Hospital leaders shall educate all Practitioners regarding appropriate professional

behavior, make employees and other personnel aware of this Policy, and shall encourage the prompt reporting of Unprofessional Conduct.

10.G ***Letters Placed in Practitioner's Confidential File.*** Copies of letters sent to the Practitioner as part of the efforts to address the Practitioner's conduct shall be placed in the Practitioner's confidential file. The Practitioner shall be given an opportunity to respond in writing, and the Practitioner's response shall also be kept in the Practitioner's confidential file.

10.H ***Supervising Physicians and Advanced Practice Professionals.*** Except as noted below, an appropriate supervising or collaborating physician shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving an Advanced Practice Professional with whom the physician has a supervisory or collaborative relationship. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

10.I ***Delegation of Functions.***

(1) When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

10.J ***Professionalism Manual.*** The Leadership Council shall approve forms, checklists, template letters and other documents that assist with the implementation of this Policy. Collectively, these documents are known as the Professionalism Manual. Such documents shall be developed and maintained by the PPE Specialists.

Individuals performing a function pursuant to this Policy should use the document currently approved for that function and revise as necessary.

10.K ***Substantial Compliance.*** While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

10.L ***Legal Protections.*** Practitioners have significant personal legal protections from various sources when they perform functions described in this Policy as long as they maintain confidentiality and act in accordance with the Policy. These legal protections are further described in Article 7 of the Medical Staff Bylaws.

10.M ***Professionalism Issue Summary Form.*** Once a professionalism concern is resolved, the PPE Specialists should complete the Professionalism Issue Summary Form and maintain this within the Practitioner's confidential file. These forms facilitate the identification of trends, inform the determinations made by the Medical Staff Leaders, CMO, and Leadership Council when assessing professionalism issues, and supplement both the OPPE and reappointment processes. A Professionalism Issue Summary Form is included as PM-16 in the Professionalism Manual.

10.N ***Reports to Medical Executive Committee, Practitioners and Board.*** The Leadership Council shall prepare reports at least annually that provide aggregate information regarding the professionalism review process (e.g., numbers of concerns reviewed by department or specialty; the types of dispositions for those concerns; etc.). These reports should be disseminated to the Medical Executive Committee, all Practitioners at the Hospital, and the Board for the purposes of reinforcing the primary objectives outlined in Section 1 of this Policy and permitting appropriate oversight. A sample Summary Report for Professionalism Review Activities to Be Provided to All Practitioners, MEC, and Board is included as PM-17 in the Professionalism Manual.

10.O ***Agreement to Voluntarily Refrain from Exercising Clinical Privileges or Other Practice Conditions.***

(1) At any point in the review process described in this Policy, the Leadership Council or its representatives may ask a Practitioner to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, Medical Staff Leaders and the Practitioner may also agree upon practice conditions that will protect the Practitioner, patients, and staff during the review process. Prior to any such action, the Practitioner shall be given the opportunity to discuss these issues with the Leadership Council or its representatives and provide written input regarding them.

(2) These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or final finding of responsibility for the concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

(3) In light of the voluntary and non-disciplinary nature of these actions, they do not generally represent matters that require any report to any State Board or to the National Practitioner Data Bank.

10.P ***Definitions.***

(1) ***Unprofessional Conduct.***

(a) Unprofessional Conduct is conduct that is inconsistent with the ethical obligations of health care professionals or that adversely affects the health care team's ability to work effectively. Unprofessional Conduct includes behavior that has a negative effect on morale, concentration, collaboration, and communication.

(b) Examples of Unprofessional Conduct are included in Appendix B to this Policy.

(c) This Policy is not intended to interfere with a Practitioner's ability to express, in a professional manner and in an appropriate forum:

(1) opinions on any topic that are contrary to opinions held by other Practitioners, Medical Staff Leaders, or Hospital personnel;

(2) disagreement with any Medical Staff or Hospital Bylaws, policies, procedures, proposals, or decisions; or

(3) constructive criticism of the care provided by any Practitioner, nurse, or other Hospital personnel.

(2) ***Sexual Harassment and Other Identity-Based Harassment.***

(a) Sexual Harassment and other Identity-Based Harassment is a form of Unprofessional Conduct, and includes verbal or physical conduct that:

(1) is unwelcome and offensive to an individual who is subjected to it or who witnesses it;

(2) could be considered harassment from the objective standpoint of a "reasonable person"; and

(3) is covered by state or federal laws governing discrimination. This includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination.

(b) Examples of Sexual Harassment and other Identity-Based Harassment are included in Appendix B to this Policy.

(c) Tests and standards used by courts to determine if conduct violates federal or state law (e.g., Title VII of the Civil Rights Act) are not dispositive in determining whether conduct is Sexual Harassment or Other Identity-Based Harassment for purposes of this Policy. Instead, the standard set forth in this section shall govern, as interpreted by the Leadership Council, Medical Executive Committee, and/or Board of Directors. The intent of this provision is to create higher expectations for professional behavior by Practitioners than the minimum required by federal or state law.

(3) ***Definitions of Other Terms.***

(a) ***"Collegial Counseling"*** means a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. Collegial Counseling only occurs after a Practitioner has had an opportunity to provide input regarding a concern. If the Collegial Counseling results from a matter that has been reported to the PPE Specialists and reviewed through this Policy, it shall be followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the Practitioner's future practice in the Hospital. A copy of the follow-up letter will be included in the Practitioner's file along with any response that the Practitioner would like to offer.

In contrast, informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts that do not meet the criteria for a Collegial Counseling are referred to as "Initial Mentoring Efforts." This Policy encourages the use of Initial Mentoring Efforts to assist Practitioners in continually improving their practices. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, documentation is recommended particularly if a pattern of behavior may be developing. Any documentation will be maintained in the Practitioner's confidential file.

(b) ***"Employed Practitioner"*** means a Practitioner who is employed by an Employer.

(c) ***"Employer"*** means:

(1) the Hospital; or

(2) a Hospital-related entity or a private entity that:

(i) has a formal peer review process and an established peer review committee; and

(ii) is subject to the same information sharing policy as the Hospital, or has information sharing provisions in a professional services contract or in a separate information sharing agreement with the Hospital.

(d) ***"Investigation"*** means a non-routine, formal process as outlined in the Medical Staff Bylaws to review concerns pertaining to a Practitioner. Only the Medical Executive Committee has the authority to initiate and conduct an Investigation. By contrast, the process to address issues of professional conduct as outlined in this Policy does not constitute an Investigation.

(e) ***"Medical Staff Leader"*** means any Medical Staff Officer, Department Chair or committee chair.

(f) ***"PPE Specialists"*** means the clinical and non-clinical staff who support the review of issues related to professionalism described in this Policy and who act at the direction of the Leadership Council. This may include, but is not limited to, staff from the quality department, medical staff office, human resources, and/or patient safety department. Documentation the PPE Specialists create are records of the Leadership Council. The Leadership Council Chair or CMO may direct PPE Specialists to perform functions under this Policy on behalf of the Leadership Council.

(g) ***"Practitioner"*** means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Advanced Practice Professionals.

11. AMENDMENTS

11.A *Review by System Leadership Group.*

(1) If the MEC wishes to amend this Policy, it shall first submit the proposed amendments to a system leadership group comprised of the following: (a) the CMO of each MH Hospital (or the CEO if the hospital has no CMO);

(b) the Medical Staff President of each MH Hospital; and (c) the MH General Counsel.

(2) The role of this system leadership group is to assess whether the amendment is appropriate and helpful for the Hospital, but also whether it would be beneficial for other MH Hospitals and foster the goals of sharing expertise within the system and promoting consistency.

(3) Following its assessment, the system leadership group will provide its report and recommendation to all relevant MH Hospitals.

11.B ***Amendments Relevant to Only the Hospital.***

(1) After receiving a favorable recommendation from the system leadership group, the MEC may approve the amendment by a majority vote and then forward it to the Hospital Board for review and adoption.

(2) However, if the system leadership group has any questions or concerns about the proposed amendment, it will convene a meeting with the MEC to discuss and resolve whether to proceed with the amendment. If the disagreement cannot be resolved, the proposed amendment will be forwarded to the Hospital Board for its review with the concerns of the system leadership group being noted.

11.C ***Amendments Relevant to More Than One MH Hospital.***

(1) After receiving a favorable recommendation from the system leadership group, the MEC for each relevant MH Hospital may approve the amendment by a majority vote and then forward the amendment to its Board for review and adoption.

(2) If there is any disagreement among the MECs concerning the amendment, a joint meeting of the MECs (or their representatives) and representatives of the system leadership group shall be scheduled to discuss and resolve the disagreement. In the unlikely event that a consensus cannot be achieved at that meeting, the proposed amendment shall be forwarded to the MH Board for further discussion and review.

11.D ***Board Action.*** No amendment shall be effective unless and until it has been approved by the Hospital Board.

Adopted by the MEC: July 28, 2022.

Approved by the Board of Directors: August 31, 2022.

JACKSONVILLE MEMORIAL HOSPITAL

Appendix A: Review Process for Concerns Regarding Professional Conduct

Reported concern regarding professional conduct

Log-in, Follow-Up, and Initial Triage

PPE Specialists (or Designee, such as Manager or HR Representative):

1. Log-in referral to peer review database
2. Follow up with individual who reported concern
3. Screening process approved by Leadership Council to confirm reported concern involves professional conduct (with periodic aggregate reports to Leadership Council)

Medical Staff President or Department Chair, with CMO:

4. Determine if: (i) report involves ***minor concern;*** (ii) ***additional fact-finding*** is needed; or (iii) report may be dismissed altogether

Minor Concern

- Concern is minor ***and*** there is no pattern of behavior
- No fact-finding regarding event or need for Practitioner to respond to concern
- Medical Staff President, Department Chair, or CMO communicates with Practitioner about matter (e.g., via brief conversation or note to Practitioner) and informs the PPE Specialists
- The PPE Specialists report aggregate data to Leadership Council to permit oversight

Additional Fact-Finding

- Concern is more significant ***or*** a pattern exists
- Provide ***preliminary notification*** of concern to Practitioner
- Notify Employer, if applicable *(see **Note 1**)*
- Conduct ***additional fact-finding*** (e.g., interviews with witnesses and others) at direction of Leadership Council
- Medical Staff President/Department Chair and CMO then decide either:
  1. ***Further review required.*** Obtain input from Practitioner (use cover letter or more formal agreement to remind Practitioner of confidentiality and non-retaliation obligations) and prepare summary for review by Leadership Council
  2. ***No further review required.*** Close matter and notify Leadership Council (to allow for oversight of process and consistency)

Leadership Council

General Conduct Concern

1. Review summary report and all supporting documentation
2. Consult with or include Department Chair and/or representative of Employer *(see **Note 1**)*, if necessary or helpful in resolving concern
3. Meet with individuals involved and witnesses, if necessary
4. Meet with Practitioner, if necessary or if requested by Practitioner
5. ***Determinations***
   - A. No issue
   - B. Educational Letter, providing guidance and counsel
   - C. Collegial Counseling, providing education or coaching
   - D. Voluntary Enhancement Plan ("VEP") for Conduct
   - E. Refer to MEC
   - F. Refer to Employer for disposition, after consultation with Employer (with a report back to the Leadership Council of final action taken by Employer)

Sexual Harassment and Other Identity-Based Harassment

(e.g., based on gender, race, religion, etc.)

1. If there is a single confirmed incident:
   - A. Practitioner must acknowledge seriousness of matter, agree there will be no similar conduct in the future, and
   - B. Formal letter of admonition and warning or VEP for Conduct placed in file, as appropriate.
2. If Practitioner does not acknowledge concern or seriousness, or there are additional incidents, refer to MEC

As needed →

MEC

Review under Medical Staff Bylaws because individual refuses to cooperate with Leadership Council, VEP Options for Conduct were unsuccessful, or Leadership Council determines MEC review is required

Note 1:

An "Employer" is:

1. the Hospital;
2. Memorial Physician Services; or
3. a private entity that:
   - A. has a formal peer review process and an established peer review committee; and
   - B. is subject to the same information sharing policy as the Hospital, or has information sharing provisions in a professional services contract or in a separate information sharing agreement with the Hospital.

APPENDIX B

EXAMPLES OF UNPROFESSIONAL CONDUCT AND SEXUAL HARASSMENT/OTHER IDENTITY-BASED HARASSMENT

1. To aid in both the education of Practitioners and the enforcement of this Policy, examples of "Unprofessional Conduct" include, but are not limited to:

   (a) abusive or threatening language directed at patients, nurses, students, volunteers, visitors, Hospital personnel, or Practitioners (e.g., belittling, berating, or non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);

   (b) degrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital;

   (c) refusal or failure to answer questions, or return phone calls or pages in a timely manner as defined in the Medical Staff Bylaws documents or other applicable policies;

   (d) intentional misrepresentation to Hospital administration, Medical Staff Leaders, other Practitioners, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken;

   (e) offensive language (which may include profanity or similar language) while in the Hospital or while speaking with patients, nurses, or other Hospital personnel;

   (f) retaliating against any individual who may have reported a quality or behavior concern about a Practitioner, provided information related to such a matter, or otherwise been involved in the professional practice evaluation/peer review process in any way (this means a Practitioner may not, under any circumstances, approach and discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual);

   (g) unprofessional physical contact with another individual or other aggressive behavior that is threatening or intimidating;

   (h) throwing an object of any kind, including but not limited to any medical/surgical instrument or supply;

   (i) repeatedly failing to maintain and renew in a timely manner all credentials required by the Medical Staff Bylaws;

(j) derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff or Hospital administrative channels;

(k) unprofessional medical record entries impugning the quality of care being provided by the Hospital, Practitioners, or any other individual, or criticizing the Hospital or the Hospital's policies or processes, or accreditation and regulatory requirements;

(l) altering or falsifying any medical record entry or hospital document (including, but not limited to, incorrectly dating or timing an entry or document to give the impression it was completed prior to when it was actually completed);

(m) completing medical record entries based on a template without considering the care actually provided to the patient, or using the "copy and paste" or "pull forward" functions of the medical record to populate fields without verifying that the information is accurate for the patient in question;

(n) refusal or failure to use or use properly documentation technology (e.g., CPOE, EHR, and other approved technology);

(o) unprofessional access, use, disclosure, or release of confidential patient information;

(p) audio, video, or digital recording that is not consented to by others present, including patients and other members of the care team;

(q) use of social media in a manner that involves Unprofessional Conduct as defined in this Policy or other Medical Staff or Hospital policies;

(r) disruption of hospital operations, hospital or Medical Staff committees, or departmental affairs;

(s) refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call issues, response times, medical recordkeeping, other patient care responsibilities, failure to participate on assigned committees, failure to cooperate with utilization oversight activities, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and Hospital employees); and/or

(t) engaging in Sexual Harassment or other Identity-Based Harassment as described in Section 2 of this Appendix.

2. Depending on the circumstances, any of the examples of Unprofessional Conduct described in this Policy may also qualify as Sexual Harassment or other Identity-Based Harassment. Additional examples include, but are not limited to, the following:

(a) ***Verbal:*** innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and suggestive or insulting sounds;

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

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

(d) ***Quid Pro Quo:*** suggesting that submission to an unwelcome sexual advance will lead to a positive employment action or avoid a negative employment action; and

(e) ***Retaliation:*** retaliating or threatening retaliation as a result of an individual's complaint regarding harassment.