

**MEDICAL STAFF POLICY AND PROCEDURE
HARASSMENT AND DISRUPTIVE BEHAVIOR****POLICY STATEMENT**

This Medical Staff Policy and Procedure on Harassment and Disruptive Behavior (“Policy”) applies to members of the Medical Staff and to Allied Health Professionals, and is an elaboration on the Medical Staff Bylaws requirement that all Medical Staff members and Allied Health Professionals demonstrate the ability to work collaboratively with others so as not to jeopardize the ability of the treatment team to provide quality health care. It is the policy of Sutter Medical Center, Sacramento (“Hospital”) that all individuals be treated courteously, respectfully and in an appropriately professional manner. To that end, the Medical Staff requires all Medical Staff members and Allied Health Professionals and other practitioners exercising membership privileges or clinical privileges (collectively, “Practitioners”) to conduct themselves in a professionally appropriate and cooperative manner.

Any conduct by a Practitioner that appears to violate this Policy shall be addressed in accordance with the provisions of this Policy, unless the Chief of Staff or Medical Executive Committee, determine that the facts of the particular case warrant a different process. Any individual may report conduct or behavior that violates a Practitioner’s obligations, and may submit the report to the Human Resources Department, the Chief of Staff (or his or her designee) or the Medical Executive Committee.

PURPOSE

The purpose of this Policy is to facilitate quality patient care by promoting a safe, cooperative and professional working environment and to prevent and eliminate, to the extent reasonably possible, conduct that disrupts the operations of the Medical Staff or Hospital, adversely impacts the ability of others to perform their jobs, or creates an inappropriate environment for Hospital employees, staff, other Practitioners, or visitors. This Policy also prohibits conduct that constitutes unlawful harassment, including sexual harassment.

COOPERATION WITH HOSPITAL PERSONNEL

Notwithstanding that this Policy outlines a Medical Staff process, this Policy is intended to promote cooperation between the Medical Staff and the Hospital relative to the creation and maintenance of an appropriate work place environment and an appropriate patient care environment. One purpose of this cooperation is to streamline investigations, so that, wherever possible, there will be one (1) fact-finding process or investigation, as opposed to two (2) separate processes. Additionally, the Medical Staff recognizes and acknowledges the Hospital’s responsibility to provide an appropriate work place and patient care environment and to take appropriate corrective action if there are problems in this regard.

DEFINITIONS

Disruptive behavior by a Practitioner is defined as conduct that has a potentially adverse impact on the Hospital’s ability to provide quality patient care and provide a safe, cooperative and professional working environment and includes, but is not limited to, the following types of behavior towards other Practitioners, Hospital staff, patients or visitors:

1. Verbal abuse, including vulgar, profane and demeaning language or tone of voice;
2. Inappropriate communication, including verbal attacks that go beyond the bounds of fair and appropriate professional conduct, excessive criticism, or other conduct that is humiliating, intimidating or belittling to the recipient; or others who may be exposed to or witness the behavior;
3. Threatening behavior, including threats of physical harm or behaviors intended to inflict injury to intimidate or to alarm;
4. Physical contact that goes beyond the bounds of fair and appropriate professional conduct;
5. Combative behavior, including expressions of anger such as throwing items or destroying property;

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6. Retaliation, including adverse treatment that is reasonably likely to deter individuals from engaging in protected activity; or
7. Any behavior deemed inappropriate as outlined in any existing Medical Staff Code of Conduct or similar policy addressing conduct guidelines.

Sexual harassment is defined as:

1. Unwelcome advances, requests for sexual favors and any other verbal, visual or physical conduct of a sexual nature when (a) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment; or (2) the conduct substantially interferes with the individual's employment or creates an intimidating, hostile or offensive work environment; or
2. Discrimination on the basis of sex, gender or sexual orientation.

This Policy also prohibits discrimination and harassment on the basis of race, gender, sexual orientation, religion, color, national origin, ancestry, physical disability, mental disability, pregnancy, or marital status or other criteria which are protected criteria by state or federal law or Hospital policy.

PROCEDURE FOR SUBMISSION OF A REPORT

1. Employees, staff, Practitioners, patients or visitors may submit reports of disruptive or harassing behavior by a Practitioner to the Chief of Staff or designee, in care of the Manager or Director of the Medical Staff Services Department, an immediate supervisor, a Department Manager/Director, or to the Hospital's Human Resources Department. Events reported through other processes (i.e., Quality or Risk Management) that include allegations of disruptive or harassing behavior by Practitioners are also subject to this policy's procedures for evaluation.
2. Hospital management personnel receiving allegations or complaints of disruptive or harassing behavior by a Practitioner should promptly notify the Chief of Staff or designee and, where the behavior affects Hospital employees, shall also promptly notify the Human Resources Director. In such cases, the Human Resources Director will promptly notify the Chief of Staff (if he or she has not already been notified), or his or her designee, and provide him/her pertinent documents. Where the complaint is made by a patient, patient's family member, or a visitor, the Hospital Risk Manager should be notified. When the Medical Staff receives a report involving a Hospital employee from a source other than the Human Resources Department, the Medical Staff will promptly notify the Human Resources Director of the complaint.

ELEMENTS OF A REPORT

Reports of a behavior believed to be disruptive or harassing should be in writing and include:

1. The date and time of the incident(s);
2. If the conduct involved or affected patient care, the name and medical record number of the patient;
3. A description of the facts and circumstances surrounding the incident;
4. A description of the behavior or conduct in question;
5. The impact, if any, on patient care or Hospital or Medical Staff operations;
6. The action taken, if any, to try to remedy the situation including the identity of other persons involved;
7. The name and signature of the person submitting the complaint.

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Reports that are not submitted in writing or otherwise documented should still be addressed under this Policy or as otherwise deemed appropriate. That determination will be made by the Chief of Staff or designee in consultation with the appropriate Human Resources or Hospital personnel and legal counsel.

NOTIFICATION TO PRACTITIONER

The Practitioner who is the subject of the report will be notified that a report has been received and that it will be handled in accordance with this Policy or otherwise in accordance with the Medical Staff Bylaws, as determined by the Chief of Staff (or designee) or Medical Executive Committee. The Practitioner will be reminded of the strict policy prohibiting retaliation towards, or intimidation of, any individual who submitted a report or who is interviewed as part of the investigation of the report, and that any such conduct will itself be deemed disruptive conduct and an independent cause of discipline, regardless of the merits of the underlying complaint.

INVESTIGATION

1. The Chief of Staff or designee shall review all reports of harassing behavior or disruptive behavior alleged to have been perpetrated by a Medical Staff Member or Allied Health Professional. The Chief of Staff or designee may dismiss or re-direct reports which the Chief of Staff or designee, in consultation with the appropriate Hospital administrative personnel, determines to be unfounded or not meeting the definition of disruptive behavior or harassment.
2. For a single incident that the Chief of Staff or designee determines should be handled under this Policy, the Chief of Staff or designee shall meet with the complainant and initiate any other fact finding deemed appropriate. Such additional fact finding may be completed by the Chief of Staff or his or her designee. The Chief of Staff or designee shall also meet with the Practitioner who is the subject of the complaint. If the Chief of Staff or designee determines that the complaint has merit and that the behavior complained of was inappropriate and may be resolved without further investigation or intervention, the Chief of Staff or designee shall advise the Practitioner that the behavior is inappropriate and must cease. The Chief of Staff or designee shall document this admonishment either through a memorandum to the Practitioner's credentials or peer review file or through a letter that will be provided to the Practitioner and placed in the Practitioner's credentials or peer review file. Any written rebuttal from the Practitioner will also be placed in the Practitioner's credentials or peer review file.
3. If additional incidents occur, or if the Chief of Staff or designee determines that a pattern of inappropriate behavior has developed or is developing, or that further investigation or intervention (beyond that described in section two (2), above) may be appropriate, the Chief of Staff or designee shall initiate an investigation of the facts of the incident as well as the background or pattern of events. This investigation will be performed either by the Chief of Staff or designee with participation from Human Resources for events involving hospital employees.
4. The Practitioner shall be afforded an opportunity to be interviewed by the fact finding person or committee. The scope of any investigation will vary depending upon the facts and conclusions of the case. If the Practitioner refuses or otherwise fails to meet with the investigator, the investigation will continue and conclusions will be issued based on the available information.
5. The investigator shall use his/her judgment in determining when the investigation is thorough and complete.

FINDINGS AND COMMUNICATION

1. At the conclusion of the investigation, the investigator shall prepare a written report for the Chief of Staff or designee that includes a summary of the investigation process/methodology, findings, and recommendation(s), if any, for appropriate remedial or corrective action. The Chief of Staff or designee shall recommend any further action or, at his or her discretion, will consult with the Medical Executive Committee regarding further action.

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2. The recommended action should, at a minimum, be sufficient to prevent further conduct from occurring.
3. If applicable, the complainant shall also be notified of the disposition of the matter and that the Medical Executive Committee is charged with responsibility for taking appropriate action.
4. The Practitioner shall be notified in writing of the outcome of the investigation.

DECISION AND DELIBERATION

1. If additional incidents occur, or if the Chief of Staff or designee determines that a pattern of inappropriate behavior has developed or is developing, the Chief of Staff or designee shall have the discretion to counsel the Practitioner or to issue a formal letter of reprimand or admonition, subject to ratification by the Medical Executive Committee. If the recommendation for corrective action will result in the Practitioner having fair hearing rights under the Medical Staff Bylaws and/or require a report to the Medical Board of California or the National Practitioner Data Bank, the recommended corrective action shall be approved by the Medical Executive Committee.
2. Nothing in this Policy is intended to prohibit the Chief of Staff or other appropriate person or committee from imposing immediate corrective action, such as a summary suspension, if warranted by the facts, including in response to a single incident.
3. In those instances where the complainant is a Hospital employee or contractor, the Chief of Staff or designee shall include the Human Resources Director, or his or her designee, in the fact finding or investigation process (including as a duly appointed member of any investigating committee), and in any meetings that occur in connection with this process, including the meeting with the Practitioner who is the subject of the report. The Chief of Staff or designee shall also have the discretion to include other Hospital personnel in the process and as duly appointed members of the investigating committee, e.g., Risk Management personnel.
4. Notwithstanding the provisions of Evidence Code Section 1157, the Medical Staff may provide copies of documents arising from this process with Hospital Administration or Hospital legal counsel if the documentation is needed for the Hospital to prove in a court of law or to any enforcement or accreditation agency that appropriate corrective action was taken to address the complained of behavior.
5. These provisions are intended to be used as guidelines only. At any time, the Chief of Staff or designee may elect to proceed under the provisions of the Medical Staff Bylaws governing investigations and corrective actions. If the Chief of Staff elects to proceed under the Medical Staff Bylaws provisions, the Chief of Staff or designee may, but is not required to, include the Human Resources Director or his or her designee, in any such Medical Staff Bylaws process.

REPORTING

The Chief of Staff and Hospital Chief Executive Officer will make any reports of corrective action or investigation as are required by state and federal law.

APPROVALS:

Quality Council

Date: 2/26/07

Medical Executive Committee

Date: 5/22/07

Medical Policy Committee

Date: 6/13/07

Board of Trustees

Date: 7/12/07

Dev: 2/2007

Reviewed:

Revised: