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|  UNIVERSITY of CALIFORNIA, SAN DIEGO<br>MEDICAL CENTER | <b>MEDICAL STAFF POLICY &amp; PROCEDURE</b> |                                     |                                |
|   | Effective Date:<br><b>08/19/2004</b>        | Review/Revised:<br><b>2/19/2009</b> | Policy No.<br><b>MSP – 014</b> |
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| <b>TITLE: MEDICAL STAFF CODE OF CONDUCT - POLICY ON DISRUPTIVE PHYSICIAN</b>  |   |                                     |                                |

## PURPOSE

Disruptive Behavior is prohibited.

This policy describes the expected professional behavior and citizenship of Practitioners, as defined below, defines types of disruptive behavior that may initiate corrective action, and describes the procedure to be followed when Practitioners display disruptive behavior within the Medical Center.

## POLICY

All Practitioners will conduct themselves at all times in a courteous, professional, respectful, collegial, and cooperative manner in order to assure a high quality of medical care to patients and maintain a safe work environment. This requirement applies to interactions and communications with or relating to medical staff colleagues, Allied Health Professional Staff (NP, CRNA, P.A., nurse-midwife and psychologists), housestaff, nursing and technical personnel, other caregivers, other Medical Center personnel, patients, patients' family members and friends, visitors, and others. Disruptive behavior, as defined below, will not be tolerated.

This policy is designed to distinguish between the behavior of Practitioners who are habitually disruptive and those Practitioners who, because of fatigue or frustration, may in isolated instances engage in disruptive behavior. Nothing in this policy is intended to conflict with a Practitioner's right to engage in constitutionally free speech or to make protected disclosures, including good faith reports of improper governmental activities.

## DEFINITIONS

*"Practitioner"*- Includes all health professionals privileged to care for patients in the UCSD Medical Center under the Medical Staff Bylaws, Rules and Regulations of the Medical Center (*"Bylaws"*).

*"Disruptive Behavior"* is personal characteristics or behavior which poses a realistic and specific threat to the quality of medical care afforded to patients.

## EXAMPLES OF PROHIBITED CONDUCT

Characteristics of a Practitioner exhibiting prohibited disruptive behavior in the workplace may include, but are not limited to:

- A. Profane, disrespectful or derogatory language including the use of racial, ethnic, and gender-related epithets, jokes or slurs
- B. Unwarranted yelling or screaming
- C. Demeaning or intimidating behavior, including use of threatening or offensive gestures and verbal threats
- D. Baseless threats to get an employee fired or disciplined
- E. Unwelcome touching, striking, or pushing others
- F. Unwelcome sexual comments or innuendo
- G. Throwing, hitting, or slamming objects
- H. Outbursts of rage or violent behavior
- I. Retaliation against a person who had filed a complaint against a Practitioner for violation of these standards
- J. Inappropriately criticizing health care professionals and medical center staff in front of patients and/or their families, visitors, or other staff
- K. Inappropriate use of medical records, including chart notes

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- L. Difficulty working collaboratively with others
- M. Repeated failure to respond to a reasonable request by any care-giver for orders, instructions, or assistance with a patient
- N. Repeated failure to respond to calls or pages
- O. Inappropriate arguments with patients, family, staff, and other physicians
- P. Poor hygiene, slovenliness
- Q. Violation of other University or Medical Center policies if the conduct that violates those policies meets the definition of disruptive behavior

**MEDICAL CENTER STAFF RESPONSE TO DISRUPTIVE BEHAVIOR**

Any medical center employee or health-care practitioner (“Caregiver”) who believes that a Practitioner is subjecting him or her to disruptive behavior is authorized to take the following actions:

- A. Promptly contact his or her immediate supervisor to report the situation. The supervisor may, at his/her discretion, arrange for the transition of any necessary patient to another person in order to permit the Caregiver to avoid conversing or interacting with the disruptive Practitioner;
- B. Continue work or patient care activity elsewhere as directed by his or her supervisor; and
- C. Consult with supervisory personnel about filing, as appropriate, a written report of the alleged incident and/or complete an eQVR.

**REPORTING OF ALLEGATIONS**

All allegations of disruptive behavior by a Practitioner shall be referred to the Chief of Staff of the Medical Staff, or Vice Chief of Staff in his/her absence, for prompt review as set forth in this Policy. The Chair of the Credentials Committee will participate in the absence of both of these individuals. In the event the allegations involve the Chief of Staff, the allegation will be reviewed by the Chief Medical Officer.

**INVESTIGATION**

Under the leadership of the Chief of Staff or designee a prompt initial inquiry shall be undertaken to determine whether the complaint appears to be supported by reliable evidence. Other Medical Center personnel designated by the Chief of Staff may participate in the initial inquiry. The Chief of Staff or designee will obtain a statement from the complaining party and interview other witnesses and review documents as necessary. The complaining party shall be informed of the process to investigate and respond to such allegations and shall be informed that retaliation for making such allegations will not be tolerated. The complaining party will also be informed that his or her allegation(s) may be shared with the Practitioner who is the subject of the allegation(s). If the Chief of Staff determines that the allegation(s) are not supported by reliable evidence, the Chief of Staff shall inform the complaining party of the results of the initial inquiry and document the findings.

If the Chief of Staff or designee determines that the allegation(s) are supported by reliable evidence, the Chief of Staff and the Department Chair (or designee(s)) of the involved Practitioner shall interview the Practitioner as soon as reasonably possible, preferably by the next business day. The Practitioner will be advised of his or her obligations under this policy, that a complaint has been made, and that no retaliation against any complaining person, witness, or investigator will be tolerated. The Practitioner will be provided with sufficient information to understand and respond to the allegation(s). The Practitioner will be provided the opportunity to respond in writing as soon as reasonably possible, preferably within 48 hours. The Chief of Staff or designee will probe as necessary to complete the investigation.

As appropriate, the Chief of Staff or designee should attempt to reach a mutually acceptable resolution of the allegation. If such a resolution is reached, the investigation may stop.

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Once the investigation is completed, the Chief of Staff or designee will present his or her findings and recommendations, along with any previous findings of disruptive behavior and action taken, to the MSEC at its next regularly scheduled meeting. The Chief of Staff or designee will notify the Practitioner and his/her Department Chair in advance of the MSEC meeting and may request the Practitioner's participation at the meeting. The Practitioner may also request the opportunity to appear before the MSEC. The Medical Staff Executive Committee may accept or modify the recommended corrective action plan or agreed upon resolution.

The Chief of Staff, with input as appropriate from the Department Chair of the Practitioner, may recommend one or more of the following actions or other appropriate action. Repeated instances of disruptive behavior or failure to cooperate with any recommended action may lead to additional or stronger action being taken to address the disruptive behavior.

1. Determine that no further action is warranted;
2. Issue a written letter of concern to the Practitioner;
3. Request the Practitioner to apologize promptly to the complainant.
4. Refer the Practitioner to the Physician Well-Being Committee for evaluation;
5. Refer the Practitioner to the PACE program for appropriate anger management or other training course; or
6. Refer the Practitioner for an evaluation by a medical professional of the MSEC's choice.

The Chief of Staff may also initiate corrective action under Bylaws Article XI, Peer Review and Corrective Action. In such a case, the investigation conducted by the Chief of Staff or designee shall substitute for the investigative process set forth in Article XI, Section 6, unless the MSEC determines that additional investigation is required.

Actions 1 through 6 above shall not be considered to be medical disciplinary action and shall not be reported to the Medical Board of California or the National Practitioner Data Bank and shall not entitle the Practitioner to a hearing or appeal under Article XII of the Bylaws.

**INVESTIGATORY REPORT**

A copy of an investigative report, the Practitioner's written response, if any, and the record of action taken shall be retained in the Practitioner's credentials file. Because the investigative report is not the records and proceedings of a medical staff committee, it will not be immune from discovery under Section 1157 of the California Evidence Code.

**ACTION BY THE CEO AND GOVERNANCE ADVISORY COUNCIL ("GAC")**

If the decision of the MSEC is not in accordance with the weight of the evidence, the CEO may further investigate the allegation(s) and/or recommend such corrective action to the GAC as he or she deems reasonable. If the GAC determines that the MSEC action is inappropriate and concurs with the CEO, it may recommend any of the other actions identified above. Before instituting action, the CEO will bring the recommendation(s) of the GAC to the MSEC for further discussion.

**ADMINISTRATIVE/ INVESTIGATIVE LEAVE OF ABSENCE**

If disruptive behavior allegations are of physical violence or conduct which is seriously disruptive of hospital operations<sup>1</sup> and if the facts available to the decision-maker support such allegations (i.e., there is

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<sup>1</sup> For purposes of this policy and procedure, "seriously disruptive of hospital operation" shall mean any conduct which involves physical assault or battery with the potential for bodily harm, any intentional action which exposes an individual to bodily fluids, or any other conduct which is so outrageous that it may seriously interfere with the hospital's ability to deliver quality patient care.

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corroborating or otherwise reliable physical or testimonial evidence), appropriate action shall be taken to insure the safety of the complainant and/or to stabilize the work situation. The CEO, Chief Medical Officer and/or Chief of Staff or designee(s) will promptly attempt to assess the validity and seriousness of the allegations. If they are of opinion that the report of problem behavior is valid and constitutes physical violence or may seriously disrupt hospital operations, the person who is the subject of the complaint shall immediately be placed on administrative leave of absence by the Chief of Staff, Chief Medical Officer, CEO or Medical Staff Executive Committee. The Vice Chief of Staff or Chief Operating Officer may act in the absence of the Chief of Staff or CEO, respectively. Before the CEO or Chief Medical Officer imposes an administrative leave of absence, he or she shall make reasonable attempts to contact the Medical Staff Executive Committee. An administrative leave of absence imposed by the CEO or Chief Medical Officer that has not been ratified by the Medical Staff Executive Committee within two (2) business days (excluding weekends and holidays) shall terminate. Such administrative leave of absence shall be effective immediately upon delivery of verbal notice thereof to the affected practitioner. Verbal notice shall be confirmed by written notice to the practitioner, with copies to the CEO, Chief Medical Officer and Chief of Staff as appropriate, within three (3) working days. Such action is an alternative to, and is in no way dependent upon or limits, following the corrective action procedures set forth in the Medical Staff Bylaws.

Within seven business days (excluding weekends and holidays) after imposition of an administrative leave, the Medical Staff Executive Committee shall meet informally to more fully consider the administrative leave of absence. The affected practitioner shall be given timely notice of an opportunity, but is not required, to attend such informal meeting. The meeting is intended to identify the alleged basis for the immediate action. This meeting shall not constitute a hearing and none of the procedural rules provided in the medical staff bylaws with respect to hearing shall apply thereto.

Within five (5) business days (excluding weekends and holidays) following the informal meeting, the Medical Staff Executive Committee shall issue a written recommendation regarding the administrative leave of absence. This recommendation may be that the administrative leave of absence be continued for a specified time and purpose, that it be lifted upon particular conditions, that the administrative leave of absence be terminated or such other action as may seem warranted. Generally, an administrative leave imposed under this policy and procedure should not remain in effect for longer than twenty (20) days.<sup>2</sup>

Immediately upon imposition of an administrative leave of absence, the Chief of Staff or responsible Department Chairperson shall have authority to provide for alternate medical coverage for the patients of the practitioner still in the hospital at the time of such leave of absence. The wishes of the patient shall be considered in the selection of such alternative practitioner.

An “administrative leave of absence” for investigatory purposes shall not constitute a “summary suspension” or a “medical disciplinary cause or reason,” as that term is defined in Section 805 of the California Business and Professions Code and will not be reported to the Medical Board of California or the National Practitioner Data Bank.

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<sup>2</sup> The purpose of an administrative leave is to immediately defuse the situation and allow time for the Medical Staff Executive Committee to investigate and/or consider appropriate action. Deliberations should lead to a recommendation of attempted informal mediation or to a recommendation of corrective action. In either case there should be no need to continue the administrative leave. If the Medical Staff Executive Committee determines that there is an imminent danger to the health of an individual presented by the accused Medical or Affiliate Staff member, the appropriate remedy would be summary suspension. If there is no immediate danger, the accused should be allowed to resume practice at the hospital and the usual corrective action mechanisms should suffice.

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If at any time immediate action is necessary to protect the life or welfare of patients, prospective patients, or another person, all or part of the Practitioner's privileges or medical staff membership may be summarily suspended pursuant to Article XI, Section 11 of the Medical Staff Bylaws.

| <b>Policy: Code of Conduct/Disruptive Physician</b>          |                  |                 |
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| <b>APPROVALS:</b>  | <b>Approved:</b> | <b>Revised:</b> |
| Medical Staff Services Office<br>Credentials Committee       |                  |                 |
| Legal  |                  | 2/2008; 1/2009  |
| Medical Staff Executive Committee                            | 08/19/2004       | 2/2008; 2/2009  |
| CEO, UCSD Medical Center,<br>representing the Governing Body | 08/19/2004       | 2/2008; 2/2009  |