Code of Professional Conduct Policy  
San Francisco General Hospital

Purpose: To promote an environment of care at San Francisco General Hospital (SFGH) in which all persons at the hospital, whether employees, patients, or visitors, are treated in a courteous, respectful, and dignified manner, in order to foster the efficient operation of the Hospital and the delivery of high quality care.

This Policy supplements (but does not replace) the provisions of the Medical Staff Bylaws, ACGME and UCSF policies governing resident physicians and students, Policies and Procedures for SFGH and UCSF employees, and Collective Bargaining Agreements between the City and County of San Francisco and Unions.

Rationale: Intimidating and disruptive behaviors may foster medical errors, contribute to preventable adverse outcomes, contribute to poor patient satisfaction, increase the cost of care, and cause qualified clinicians, administrators, managers, and staff to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and promote a culture of safety, and to comply with standards mandated by the Joint Commission, San Francisco General Hospital is committed to addressing behaviors that threaten the performance of the health-care team.

Per the new Joint Commission leadership standard (LD.03.01.01), San Francisco General Hospital developed the following policy addressing two elements of performance:

EP4: SFGH has developed a code of conduct that defines acceptable versus disruptive and inappropriate behaviors.

EP5: SFGH leadership has created and implemented a process for managing disruptive and inappropriate behaviors.

Scope: All personnel involved in clinical care at San Francisco General Hospital

STANDARDS OF BEHAVIOR

Expected Behaviors:

a. All SFGH physicians and other providers, nurses, ancillary staff, administrators, employees, patients, patient family members, and other persons at the hospital are to be treated courteously, respectfully, and with dignity.

b. Communications, including spoken remarks, written documents, and electronic messages, will be conducted in a professional, constructive, respectful, and efficient manner.

c. Cooperation and availability are expected of all personnel who will report on time for all scheduled clinical, teaching, and administrative duties and respond to pages promptly and appropriately.

d. Understanding that a variety of experience levels exists, tolerance for those who are learning is expected.
Examples of Disruptive and Inappropriate Behaviors:

- Shouting, yelling or tirades.
- Use of profanity, particularly when directed at another individual.
- Slamming or throwing of objects.
- Physical or verbal intimidation and harassment.
- Hostile, condemning, or demeaning communications.
- Criticism of performance and/or competency delivered in an inappropriate location (i.e., not in private) and not aimed at performance improvement.
- Impertinent and inappropriate comments written in patient medical records, or other official documents including electronic communications, which have the primary purpose or effect of attacking or belittling other providers and staff, imputing incompetence of other providers or staff, or impugning the quality of care of other providers or staff.
- Lack of cooperation or unavailability to other practitioners or staff for exchange of pertinent patient care information or resolution of patient care issues (including patient hand offs and timely response to pages) or to participate in required patient safety procedures.
- Failure to report for clinic, patient rounds, surgery, or other scheduled patient care and teaching responsibilities without providing notice or repeated tardiness for such duties.
- Other behavior demonstrating disrespect, intimidation, or disruption to the delivery of quality patient care and an environment free of harassment and violence.
- Retaliation against any person who addresses or reports unacceptable behavior.

Expressing contrary opinions is not disruptive conduct, nor is expressing concern or constructive criticism of existing policies or procedures or questioning potentially unacceptable performance or conditions, if it is done in good faith, in an appropriate time, place and manner, and with the aim of improving the environment of care rather than personally attacking any individual.

PROCEDURES for addressing Disruptive and Inappropriate Behaviors involving patient care

Meeting for Resolution

The optimal way to address inappropriate conduct is a face-to-face meeting between the parties involved using the following steps:

- The person who was aggrieved is expected to address the issue with the other party in a timely manner and private setting using this Code of Professional Conduct as a reference.
- This meeting may be more productive after a “cooling off” period of a few hours or a few days so that the parties involved may gain perspective on the precipitating events and process breakdowns that may have been contributing factors.
- If facilitation of the discussion is needed, the unit manager or supervisor and/or appropriate leadership may serve as facilitators.
- Sincere apologies should be encouraged and every reasonable attempt should be made to defuse the situation without further intervention.
• If clinical care/hospital process deficiencies are discovered during this face-to-face meeting, these concerns will be addressed for improvement by the unit’s leadership.

• No documentation of incidents resolved by the involved parties is required unless required by policy, rule and/or law.

*Every effort should be made to have a Meeting for Resolution.* If the reporter of a Disruptive and Inappropriate Behavior feels s/he cannot initiate a meeting with the alleged party, s/he will discuss with her/his unit manager or supervisor. If the matter cannot be resolved satisfactorily, a written Code of Professional Conduct Unusual Occurrence Report shall be submitted and include an explanation as to why a Meeting for Resolution did not occur and why the matter was not resolved with the assistance of the unit manager or supervisor (Required).

Report of Alleged Disruptive and Inappropriate Behavior involving patient care

If the issue is not resolved after a reasonable attempt by the affected parties, the situation shall be reported using the confidential and 1156-protected Unusual Occurrence (UO) form, “Code of Professional Conduct Report”.

1. If the alleged conduct involves harassment, violence in the workplace, and/or discrimination, Human Resources shall be notified (415/206-8630). Allegations of harassment also must be reported to the DPH Equal Employment Opportunity Office (415/554-2595) within one business day.

2. Any person who witnesses an incident of Disruptive and Inappropriate Behavior may report the incident by completing a written Code of Professional Conduct Report and submitting to Risk Management. Reports may be submitted on-line from the CHN Intranet Unusual Occurrence website.

3. The report shall include the following as applicable:

   (i) The name of the person exhibiting the Disruptive and Inappropriate Behavior;

   (ii) The date, time, and location of the incident;

   (iii) The name of any patient, nurse, officer, employee or other person affected by the Disruptive and Inappropriate Behavior;

   (iv) A list of witnesses to the event;

   (v) A detailed, factual, and objective description of the incident;

   (vi) The consequences, if any, of the Disruptive and Inappropriate Behavior as it relates to patient care or the operations of the Hospital; and

   (vii) A record of any action taken to remedy the effects of the Disruptive and Inappropriate Behavior, including the date, time, place, action taken, and name(s) of the individual(s) intervening.
4. Risk Management will log and forward the Report for further investigation and action according to the classification of the personnel involved:

   a. **Employees**: Direct supervisor. If the incident involves Employee Disruptive and Inappropriate Behavior, Hospital Administration and/or Human Resources will be informed as well. Further action, including counseling, warning, and disciplinary action will proceed according to current MOUs and SFGH Policies and Procedures. A manager may counsel his/her employee regarding the alleged misconduct. Such counseling is not discipline. However, if the alleged misconduct may lead to disciplinary action, the employee is entitled to union representation pursuant to general labor law. A report of outcome and resolution will be logged by Risk Management via the UO system.

   b. **Residents**: Residency program Director. If the incident involves Resident Disruptive and Inappropriate Behavior, the Dean’s Office will be informed as well. Further action, including counseling, warning, and disciplinary action will proceed according to current MOUs, SFGH Policies and Procedures, ACGME and UCSF policies and procedures governing Resident conduct. A report of outcome and resolution will be logged by Risk Management via the UO system.

   c. **Students**: The course/rotation leader. If the incident involves Student Disruptive and Inappropriate Behavior, the Dean of Student Affairs for Medical Students or similar authority for other student programs will be informed as well. Further action, including counseling, warning, and disciplinary action will proceed according to the policies and procedures governing Student conduct. A report of outcome and resolution will be logged by Risk Management via the UO system.

   d. **Medical Staff**: Chief of the Clinical Service. If the incident is especially serious, the Chief of Staff and Dean will be notified as well. Further action, including requiring routine monitoring and education, Verbal Counseling, Written Counseling or initiating Corrective Action will proceed according to the terms of the Medical Staff Bylaws. If Corrective Action is implemented, it will be reported to the Medical Executive Committee, Governing Body, and California Medical Board. A report of outcome and resolution will be logged by Risk Management via the UO system.

5. At the conclusion of the investigation and resolution, the assigned supervisor will communicate the outcome to Risk Management. The supervisor also will notify Human Resources when indicated. Risk Management will log, track trends, and report aggregate data to the Performance Improvement and Patient Safety Committee (PIPS) twice annually.
Disruptive and Inappropriate Behavior

May bypass with explanation on UO

Meeting for Resolution

No

Unit Manager or Supervisor

No

Code of Professional Conduct Report (Confidential UO)

Risk Management
Receives, reviews, assigns report

Employee

Direct Supervisor +/- HR, CEO

Investigation with counseling, warning, disciplinary action as indicated by MOUs and P&Ps

Resident

Program Director +/- Dean, CEO

Investigation with counseling, warning, disciplinary action as indicated by MOUs and SFGH, ACGME and UCSF P&Ps

Student

Course Leader +/- Dean, CEO

Investigation with counseling, warning, disciplinary action as indicated by School P&Ps

Medical Staff

Service Chief +/- COS, Dean, CEO

Investigation with counseling, warning, disciplinary action as indicated by Medical Staff Bylaws

Risk Management
Logs, tracks and reports twice annually to PIPS
San Francisco General Hospital

Code of Professional Conduct Unusual Occurrence Report

[Outline of electronic reporting form on Intranet site managed by Risk Management Office]

Person exhibiting Disruptive and Inappropriate Behavior:

Date and Time of Event:

Location of Event:

1. Please describe the situation that you found to be disruptive and/or inappropriate. Please be as detailed as possible using quotes whenever possible:

2. What circumstances precipitated this event?

3. Names of Patient/Family, Employee, or Medical Staff involved:

4. List all who witnessed the event:

5. How do you think this situation impacted patient care, hospital operations, or the work environment?

6. What did you or others do to address this conduct? Did you have a face-to-face meeting for resolution? If not, why not? (Required)

    Did you address this matter with your unit manager or supervisor? (Required)

7. How would you like to see the situation resolved?

Name of person completing form:

Department:  Date:

IMPORTANT NOTE: If the behavior you experienced involves any form of harassment (including, but not limited to harassment based on race, color, sex, religion, national origin, age or disability), violence, or the threat of violence, please contact any member of administration or the Human Resources Department at 415/206-8630.
Medical Staff Procedures

[To be incorporated into Medical Staff Bylaws]

Investigation of Alleged Disruptive and Inappropriate Behavior by Medical Staff Members

The Code of Professional Conduct Unusual Occurrence Report will be received and logged by Risk Management. A copy of the Report will be forwarded to the Chief of Service. The Chief of Service or designee shall perform an initial investigation, soliciting perspectives from all parties relevant to the incident, within one week. The Chief of Service, in consultation with the Chief of Staff, Dean, Chief Medical Officer and/or Administrative Executives as needed, will assign a preliminary plan of action based on severity of the behavior using the following tiers:

I. **No Action:** The alleged behavior does not meet the level of Disruptive and Inappropriate Behavior as defined by the Code of Professional Conduct.
   
   Where the Chief of Service concludes that an alleged instance of Disruptive and Inappropriate Behavior does not rise to the level defined in the Code of Professional Conduct Policy, no further action shall be taken. The Chief of Service will report this outcome to Risk Management.

II. **Meeting for Resolution:** The behavior is relatively minor, had low potential to adversely affect patient care, and likely can be resolved by a meeting of the involved parties.
   
   The Chief of Service will convene and facilitate a face-to-face Meeting for Resolution between the Member and the affected party. The Chief of Staff may help identify an alternative facilitator/mediator upon request. The Chief of Service will report this outcome to Risk Management upon successful resolution.

III. **Verbal Counseling:** The behavior had the potential to adversely affect patient care, is a first event for the Member, and the Disruptive and Inappropriate Behavior is not of a sufficient nature to warrant more formal action by the Medical Executive Committee.
   
   The Chief of Service shall verbally counsel the Member when an instance of Disruptive and Inappropriate Behavior warrants such counseling. The Verbal Counseling shall emphasize the particular conduct that is inappropriate and stress that future similar conduct may result in more formal action under the procedures of the Medical Staff Bylaws. A record of the Verbal Counseling will be kept by the Chief of Service and will include expectations, the action plan, and the consequences of repeat behavior of a similar nature (which will include Written Counseling). The Member also may be directed by the Chief of Service to issue an apology. The Chief of Service will report this outcome to Risk Management.

IV. **Written Counseling:** The behavior had the potential to adversely affect patient care, is not of a sufficient nature to warrant more formal action by the Medical Executive Committee, but is sufficiently serious to make Verbal Counseling inappropriate OR it represents **recurrent** Disruptive and Inappropriate Behavior.
The Chief of Service will meet with the Member and write a formal letter that sets forth the serious nature of the Disruptive and Inappropriate Behavior, reiterates any previous verbal counseling in relation to similar Disruptive and Inappropriate Behavior exhibited by the Member, emphasizes the responsibility of Medical Staff Members to treat all persons at the Hospital courteously, respectfully, and with dignity. The letter will include expectations, the action plan, and the consequences of repeat behavior of a similar nature (which may include referral for Corrective Action). The Member also may be directed by the Chief of Service to issue an apology. A copy of the Written Counseling shall be sent to the Chief of Staff, the Dean, the Chief Executive Officer and the Medical Staff Office for inclusion in the Member’s peer review (“credentials”) file. The Medical Staff Member may submit a letter of rebuttal that will be placed in the Member’s peer review file. The Chief of Service will report this outcome to Risk Management.

V. **Corrective Action:** The behavior has the potential to be seriously disruptive to the operation of the Hospital, the functioning of the Medical Staff, or the delivery of high quality medical care at the Hospital, **OR** it represents a documented pattern of Disruptive and Inappropriate Behavior by a Member.

A documented pattern of Disruptive and Inappropriate Behavior by a Member in accordance with the Code of Professional Conduct Policy shall constitute *prima facie* evidence of conduct that is disruptive to the operation of the Hospital, the functioning of the Medical Staff, and the delivery of high quality medical care at the Hospital. The Chief of Service will refer the matter to the Medical Executive Committee for Investigation under Article 6.2 of the Bylaws. The Chief of Service will report this outcome to Risk Management.

The Chief of Service is encouraged to consult freely with the Chief of Staff, Dean, Chief Medical Officer, and/or Executive Administrators in determining the appropriate plan of action. The level of action may be revised by the Chief of Service, in consultation with the Chief of Staff, Dean and/or Chief Medical Officer as appropriate, after further information is obtained in the course of investigation and counseling.

Risk Management will log Code of Professional Conduct UO reports and outcomes, track trends, and report aggregate data to the Performance Improvement and Patient Safety Committee (PIPS) twice annually.
Chief of Service
Performs initial investigation,
in consultation with COS, Dean, CMO, CEO

No Action warranted; Resolved

Notify Risk Management

Meeting for Resolution
Chief of Service
Convenes meeting
Documentation of Meeting
Notify Risk Management of outcome and maintain documentation in department file

Verbal Counseling
Chief of Service
Counsels Member, documents
Documentation of Counseling
Notify Risk Management of outcome and maintain documentation in department file

Written Counseling
Chief of Service
Counsels Member, documents
Documentation of Counseling
Notify Risk Management of outcome and submit letter to COS, Dean, CEO, and peer review file, and maintain documentation in department file

Corrective Action
MEC
Initiates Investigation per Article VI of the Bylaws

Written Counseling
Chief of Service
Counsels Member, documents

Chief of Service
Counsels Member, documents

Medical Staff