CHA HUMAN RESOURCES COMMITTEE

February 28, 2017
11 a.m. - 3:30 p.m.

Huntington Hospital
Wingate Building, Board Room
100 West California Blvd
Pasadena, CA 91105

AGENDA

ITEM	TIME	SUBJECT	REPORTING	PAGE
I.	11 - 11:15 am	**WELCOME, INTRODUCTIONS & SEPTEMBER MEETING MINUTES** A. HR Committee Roster: changes to Michele Coughlin B. 2017 Final Meeting Schedule and BoardEffect	Braun	3
II.	11:15 - 11:30 am	**CHA POLITICAL ACTION COMMITTEE**	Blanchard-Saiger	8
III.	11:30 a.m. - 12:15 pm	**MEMBER ROUNDTABLE DISCUSSION**	All	
IV.	12:15 - 12:45 pm	**LUNCH**		
V.	12:45 - 1:15 pm	**ALLIED FOR HEALTH SURVEYS**	Hollingsworth	14
VI.	1:15 - 1:30 pm	**LABOR UPDATE**	Blanchard-Saiger	15
VII.	1:30 - 2:00 pm	**LEGISLATIVE, REGULATORY AND LITIGATION UPDATE** A. 2017 Legislation B. Regulatory Update C. Case Update D. Paid Sick Leave	Blanchard-Saiger	16
VIII.	2:00 - 2:15 pm	**WORKPLACE VIOLENCE PREVENTION REGULATIONS** A. Status B. Member Support Needs	Blanchard-Saiger	17
IX.	2:15 - 2:45 pm	**EDUCATION** A. 2017 Hospital Employee Safety & Workers Compensation Seminar - Status B. 2017 Labor & Employment Law Seminar - Planning for 2017	Blanchard-Saiger	18
X.	2:45 - 3:30 pm	**EMERGING ISSUES** A. Impact of the new Administration B. LGBTQ Policies and Practices C. Medical Staff & HR Coordination	All	27
XI.	3:30 pm	**ADJOURN**	Braun	

ANTITRUST POLICY STATEMENT

This meeting will bring together representatives of organizations that are competitors to explore issues that might provide general benefit to the industry. Although the subject matter of these discussions is not intended to restrain competition in any manner, it is important for everyone to recognize that this meeting conceivably could be characterized as an opportunity for inappropriate information exchanges or agreements that result in anticompetitive or otherwise unlawful conduct in violation of the antitrust laws.

It is the intent of all participants that this meeting and their participation in it will comply fully with all legal obligations. In particular, any discussions or agreements that could raise antitrust concerns are entirely beyond the bounds of this meeting and the advice of legal counsel will be sought if there is any question in this regard. Similarly, any questions about the appropriateness of a discussion topic or a particular piece of information to be shared should be raised with the legal counsel before they are shared with the group. Discussing the following categories of information should be avoided:

1. Profits, premiums, prices, surcharges, or discounts;
2. Current or forward-looking wage and other compensation information, including actual figures as well as strategies;
3. Rate of hiring and number of personnel to be hired;
4. Any refusal to deal with an employee or class of employees;
5. Allocation of geographic or product markets;
6. Any other topic involving any possible anticompetitive practice.

Another key issue to keep in mind is that even though employees, through their unions, may legally coordinate with one another through the collective bargaining process, hospitals must act independently and unilaterally in negotiating with unions (absent a valid multi-employer bargaining arrangement).

Discussion of the meaning and interpretation of legislative and regulatory developments is permissible. However, if the discussion moves towards an exchange among hospitals about how those developments are affecting the levels of compensation each will offer, the rate of hiring, or other competitively sensitive subjects, then those topics could expose roundtable participants to potential risk.

These discussions and any actions resulting from them are not intended to play any role in the individual competitive business decisions of the participating companies, nor in any way restrict competition among them or with respect to the industries they serve. It is the responsibility of every participant to be guided by this policy of strict compliance with the antitrust laws and to raise any concerns with possible violations of this policy promptly.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 28, 2017

TO: Human Resources Committee

FROM: Gail Blanchard-Saiger, Vice President & Counsel, Labor & Employment

SUBJECT: Introduction

I. DISCUSSION

A. Review contact information and titles contained on the attached roster

B. Review 2017 meeting schedule

C. Update on use of BoardEffect

CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

Human Resources Committee
ROSTER

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Open

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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

Human Resources Committee

2017 Meeting Dates

Tuesday, February 28, 2017
11:00 a.m. – 3:30 p.m.
Huntington Hospital
100 W California Blvd
Pasadena, CA 91105

Tuesday, May 30, 2017
9:30 a.m. – 2:00 p.m.
Sutter Health
2000 Powell Street
10th Floor Board Room
Emeryville, CA 94608

Tuesday, July 25, 2017
1:00 p.m. – 2:30 p.m.
800-882-3610
PIN: 7940090#

Thursday, September 7, 2017
9:30 am - 2:00 pm
Cottage Health
400 Pueblo Street
Santa Barbara, CA 93105

Tuesday, November 9, 2017
9:30 a.m. – 2:00 p.m.
Shriners Hospital for Children Northern California
2425 Stockton Blvd, 7th Floor Boardroom
Sacramento, CA 95817

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 28, 2017

TO: Human Resources Committee

FROM: Gail Blanchard-Saiger, Vice President & Counsel, Labor & Employment

SUBJECT: CHA Political Action Committee

I. ACTION REQUESTED

Introduction to the CHA Political Action Committee

II. SUMMARY AND BACKGROUND

CHPAC is the political advocacy arm for hospitals and is the foundation upon which CHA's member hospitals and health systems build relationships.

CHPAC provides a voice for hospitals and health systems which affect hospitals' ability to fulfill their missions. CHPAC also helps ensure that elected officials making important decisions understand the fundamental roles hospitals and health systems play in the future of health care.

- CHPAC exists to elect, educate and build rapport with legislators and officials who understand the important role hospitals play in our state.
- CHPAC provides campaign financing to officeholders and candidates who are concerned about and committed to better health care for all Californians.
- CHPAC determines which candidates to support based on qualifications, knowledge, sensitivity and responsiveness to health care issues.

California Hospitals
Provide Care and Employ Thousands.

Support the Hospitals that Support You.

Join CHPAC today!

CHPAC
CALIFORNIA HOSPITAL ASSOCIATION
Political Action Committee
QUALITY HEALTH CARE FOR CALIFORNIANS

What is CHPAC?

California Hospital Political Action Committee (CHPAC) is the political arm of the California Hospital Association. The purpose of CHPAC is to elect candidates who understand the vital role hospitals play in our state as a part of the health care system, and the positive impact hospitals have on the economy.

CHPAC receives contributions from individuals and corporate members and uses those funds to support officeholders and candidates for state and local offices.

The CHPAC Board of Directors governs the activities and funds of CHPAC. The board includes health care leaders from across the state as well as corporate partners.

Why give to CHPAC?

As it becomes increasingly difficult for companies to do business in California, it is imperative that we help to elect candidates who understand and support hospitals. It is vital for hospitals to provide quality care while also maintaining the financial stability necessary to employ a workforce of more than a half-million individuals. Additionally, California hospitals purchase vast amounts of goods and services, further fueling the economy by supporting both small and large businesses.

Individual Advocacy Levels

CHPAC Presidents' Club Platinum ($5,000)

The prestigious Presidents' Club Platinum level signifies the highest level of commitment at the individual level.

- Includes all Presidents' Club Diamond level benefits.
- A special executive dinner and reception

CHPAC Presidents' Club Diamond ($1,750)

- Free admission (with one guest) to all CHPAC events
- Invitations to legislative briefings and receptions featuring key lawmakers who are active in health care policy
- Recognition throughout the year at CHPAC events and in publications
- An elite-level CHPAC lapel pin

CHPAC Presidents' Club ($1,500)

- Free admission (with one guest) to all CHPAC events
- Invitations to legislative briefings and receptions featuring key lawmakers who are active in health care policy
- Recognition throughout the year at CHPAC events and in publications
- A specially-designed CHPAC lapel pin

CHPAC Leadership Board ($850)

- Invitations to legislative briefings and receptions featuring key lawmakers who are active in health care policy
- Recognition throughout the year at CHPAC events and in publications
- A specially-designed CHPAC lapel pin

CHPAC Golden State Club ($500)

- Recognition throughout the year at CHPAC events and in publications
- A specially-designed CHPAC lapel pin

Corporate Sponsorship Levels

Membership in the CHPAC Corporate Presidents' Club is for corporations that have a vested interest in the vitality of hospitals and are committed to working with CHPAC to help elect policy makers who understand the important role hospitals play in their communities. Vendors and businesses that supply goods and services to the state's hospitals and health systems may demonstrate their support and commitment to their clients by joining the CHPAC Corporate Presidents' Club.

Corporate Presidents' Club ($7,300)

- Free admission for three company representatives to CHPAC's Presidents' Club events. CHPAC holds a dozen events throughout the year, which are held at great venues, and provide excellent opportunities for our member companies to network with area hospital executives. Your company will receive recognition on the invitation and throughout the event.
- Recognition in publications throughout the year that reach an audience of over 400 heath care administrators and CEOs
- Members can request a personal meeting with hospital executives by submitting a form.
- Corporate profile on the CHA website, with a link to your company website

Platinum Corporate Presidents' Club ($12,000)

- Includes all Corporate Presidents' Club level benefits
- Sponsorship and premier recognition at one Presidents' Club event

CHPAC Executive Committee

Chair

Past Chair
Sherri Sager
Chief Government/Community Relations Officer
Lucile Packard Children's Hospital

Secretary/Treasurer
Thomas Hiltachk
Attorney at Law
Bell, McAndrews & Hiltachk, LLP, Sacramento

C. Duane Dauner
President/CEO
California Hospital Association, Sacramento

Jill Thomson
CHPAC Executive Director
California Hospital Association, Sacramento

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California Hospital Association, Sacramento

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www.calhospital.org/chpac

CHPAC-FED
CALIFORNIA HOSPITAL ASSOCIATION
Political Action Committee

QUALITY HEALTH CARE FOR CALIFORNIANS

2017 Federal Contribution Form

Yes, I wish to support the federal activities and causes of the California Hospital Association Political Action Committee Federal (CHPAC-FED) by making a contribution of:

Amount

☐ Presidents' Club Platinum Level ($5,000)
☐ Presidents' Club Diamond Level ($1,750)
☐ Presidents' Club ($1,500)
☐ Leadership Board Challenge ($850)
☐ Golden State Club ($500)
☐ Other ($_____)

Recurrence

Pledges must be paid in full by December 31

☐ One-time ☐ Monthly ☐ Quarterly ☐ Payroll (association staff)

Personal Information

Federal law requires this information accompany all contributions:

Name:

Occupation/Title:

Full Name of Employer:

Physical Address:

City: State: Zip:

Telephone: Email

Payment Information

☐ Check enclosed. Make payable to CHPAC-FED
☐ Billing address same as Personal Address
☐ I verify that this is a personal donation for which I will not be reimbursed by my employer or any other entity

Name on Card:

Card Number: Expiration Date:

CVV Number:

Billing Address:

City: State: Zip:

CHPAC Goal Credit

Name of hospital(s) or regional association to receive credit:

Please give recognition to my professional organization

☐ ACNL ☐ CSHE ☐ HCE ☐ HHRMAC ☐ Volunteers

Federal PAC Guidelines for Contributing to CHPAC-FED

The purpose of CHPAC-FED is to support the election of candidates to the U.S. House of Representatives and U.S. Senate who recognize the vital role of hospitals.

Contributions or gifts to CHPAC are completely voluntary and not deductible as charitable contributions for federal or state income tax purposes.

Contribution levels are suggestions — you may contribute more or less. You have the right to refuse to contribute to CHPAC-FED without reprisal. The decision to participate will in no way affect your employment or job status.

CHPAC-FED may accept contributions from individuals up to $5,000 per calendar year.

CHPAC-FED is prohibited by federal law from accepting contributions from corporations, labor unions, federally chartered corporations, federal government contractors, foreign nationals and persons who are not members of the solicitable class.

CHPAC-FED may solicit only individuals who are officers, directors, shareholders or management employees of member corporations and their families. As an officer, director, shareholder or management employee of a member corporation or a family member of such persons, please complete the required contributor information.

CHPAC-FED will not accept any contribution until it has confirmed that the contributor is a member of the CHPAC-FED solicitable class. Any contributions received from persons who are not members of the CHPAC-FED solicitable class will be transferred to the CHPAC state account.

Paid for by CHPAC Federal Political Action Committee
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CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 28, 2017

TO: Human Resources Committee

FROM: Gail Blanchard-Saiger, Vice President & Counsel, Labor & Employment

SUBJECT: Allied for Health Survey

I. ACTION REQUESTED

Provide feedback on Allied for Health Surveys

II. SUMMARY AND BACKGROUND

For over 50 years, HASC, on behalf of CHA and Regional Associations, have produced annual Allied for Health Compensation Reports to help members make strategic and informed compensation decisions. Most recently, HASC and consultants from FutureSense, LLC convened three regional meetings with the Compensation Practices Committee to discuss survey reports from both a strategic and tactical perspective. The regional meetings also provided an opportunity to solicit the committee's input to help guide the association in developing future surveys.

Teri Hollingsworth will provide a report on the regional Compensation Practices Committee meetings, share survey changes resulting from the input received and discuss the most recently published Labor Union Penetration Report.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 28, 2017

TO: Human Resources Committee

FROM: Gail Blanchard-Saiger, Vice President & Counsel, Labor & Employment

SUBJECT: CHA Labor Update

I. ACTION REQUESTED

Provide regional labor updates in the context of the issues presented.

II. SUMMARY AND BACKGROUND

Regan's 11/5/14 email to hospital CEOs	Ordered to arbitration	Pending
Exec Comp Initiative	Ordered to arbitration	CHA prevailed
UHW's breach of fiduciary duty lawsuit	Ordered to arbitration	Pending
UHW's refusal to release funds held by LMC	Ordered to arbitration	Pending
Regan's breach of fiduciary duty lawsuit	Ordered to arbitration	Pending

The joint labor management committee (Caring for Californians) is still in existence. However, all consultant and support agreements, including the lease, were terminated as of October 31, 2016. The Executive Director's contract was terminated effective November 30.

SEIU-UHW has sponsored at least one adverse bill thus far pertaining to emergency department closures.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 28, 2017

TO: Human Resources Committee

FROM: Gail Blanchard-Saiger, Vice President & Counsel, Labor & Employment

SUBJECT: Legislative, Regulatory and Litigation Update

I. ACTION REQUESTED

Provide input on pending legislation and regulations.

II. SUMMARY AND BACKGROUND

The attachment provides a summary of major 2017 labor and employment legislation as well as pending regulatory activity and litigation where CHA has filed amicus briefs. (To be distributed at the meeting)

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 28, 2017

TO: Human Resources Committee

FROM: Gail Blanchard-Saiger, Vice President & Counsel, Labor & Employment

SUBJECT: Workplace Violence Prevention Regulations

I. ACTION REQUESTED

Provide feedback on activity to-date. Recommend member support activities.

II. SUMMARY AND BACKGROUND

The Cal/OSHA Healthcare Workplace Violence Prevention regulations were finalized late last year. While the regulations go into effect on April 1, 2017, hospitals have until April 1, 2018 to comply with most provisions (exceptions are recording, reporting and recordkeeping). CHA and the Healthcare Workplace Violence Prevention Workgroup have actively participated in the regulatory process and CHA has provided the following member support activities:

- Creating and maintaining a dedicated CHA Healthcare Workplace Violence Prevention webpage
- Providing prompt and regular updates in CHA News
- Hosting regional roundtables with the regional associations
- Delivering a webinar with speakers from Cal/OSHA
- Creating a guidebook
- Devoting a significant portion of the agenda at the CHA Employee Safety and Workers' Comp seminar to provide an update, particularly on the reporting obligation, as well as information from a hospital safety executive as to her compliance efforts

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 28, 2017

TO: Human Resources Committee

FROM: Gail Blanchard-Saiger, Vice President & Counsel, Labor & Employment

SUBJECT: CHA Education

I. ACTION REQUESTED

Input on Marketing for 2017 CHA Employee Safety and Workers' Compensation Seminar and planning the agenda for the 2017 CHA Labor and Employment Law Seminar.

II. SUMMARY AND BACKGROUND

CHA offers two annual seminars for CHA-member executives and staff focused on various human resources-related functions. As the human resources landscape evolves, hospitals must stay informed about new laws, regulations, important case decisions, and shifting enforcement positions that will impact operations and employee relations. To serve this need, CHA offers the Employee Safety and Workers' Compensation Seminar in the spring and the Labor and Employment Law Seminar in the fall.

The 2017 CHA Employee Safety and Workers' Compensation Seminar agenda is set based on input from November's meeting. The Committee will discuss marketing efforts. Staff requests input on the agenda for the 2017 CHA Labor & Employment Law Seminar.

CHA **Seminars**

Hospital Employee Safety and Workers' Compensation Seminar

- **Cal/OSHA workplace violence prevention regulation**
- **Managing employee leaves and absences**
- **Using data, metrics to improve employee programs**
- **Support for employee well-being**

March 22 Sacramento
March 30 Costa Mesa

CALIFORNIA HOSPITAL ASSOCIATION

Hospital Employee Safety and Workers' Compensation Seminar

Hospitals are charged with providing care that improves the health and well-being of their patients. To work effectively, hospital employees must feel safe, protected and supported – both in the workplace and in their lives. Sustaining a culture of worker safety means knowing the laws and regulations impacting these areas, as well as providing employee programs that prevent hazards and offer a more holistic approach to employee safety.

Join us for this information-packed seminar that will help you refine and enhance your employee safety and workers' compensation programs. Sessions at this year's event include:

- Cal/OSHA's workplace violence prevention regulation – steps for implementation and compliance
- Employee leaves/absences – managing lost time, and how to encourage and prepare for return to work
- Policy update from the director of the Department of Industrial Relations
- How to use data and metrics to develop employee programs and improve processes
- Offering psychological and emotional support for work-related events and life issues
- And more.

Plan now to attend this members-only seminar — first program is March 22.

Who should attend

Health care professionals working in:

- **Human resources**
- **Employee/occupational health**
- **Workers' compensation**
- **Risk management**
- **Nursing leadership**
- **Safety and security**

"Came away with new ideas to improve processes at our facility."

"Excellent presentations with great takeaways to share at our hospitals!"

"Knowledgeable speakers, helpful information."

"Very educational and helped me understand new standards."

— Participant comments from last year's seminar

Agenda

8:30 a.m. – 12:00 p.m.

Implementing Cal/OSHA's Workplace Violence Prevention Regulation

- Details on the final regulation – key dates and deadlines
- Strategies for successful implementation – developing a plan, hazards assessment, corrective action and training
- Reporting obligations – what, how and when to report

Employee Leaves of Absence and Return to Work

- The costs behind employee leaves/absences
- Encouraging a rapid return – alternate positions, return to work and other support programs
- Manager/Employee engagement *before* an injury occurs
- Getting it right – promising practices and approaches

Department of Industrial Relations Policy Outlook

- Current DIR initiatives and focus
- 2017-2018 Work Plan

12:00 – 1:00 p.m. | **Hosted Luncheon**

1:00 – 4:00 p.m.

Making the Numbers Work – Using Data and Metrics to Improve Programs and Processes

- Identifying and gathering relevant data from various sources
- Merging the data, and using metrics to evaluate and improve employee programs
- Establishing benchmarks and performance targets, quality control for data accuracy

Support for Employee Well-Being

- Crisis protocol for work-related incidents
- Psychological/emotional support for positive life balance
- Offering resources to help employees manage stressors

Legislative and Regulatory Update

- 2017 legislation overview
- Regulatory activity – indoor heat illness, Fed/OSHA agenda

Faculty

Christine Baker, Director, Department of Industrial Relations

Gail Blanchard Saiger, Vice President, Labor and Employment, California Hospital Association

Angeli Mancuso, RN, COHN-S/CM, Manager, Employee Health and Safety, Cottage Health

Helen Neppes, Director, Work Life Services, Scripps Health

Dan Perrot, CIH, CSP, Director, Employee Health and Safety, Total Health & Productivity Management, Sutter Health

Tarane Sondoozi, PsyD, CEAP, Employee Assistance Professional and Adjunct Faculty, Center for Learning and Innovation, Scripps Health

Hsu Tan, Director, Informatics and Risk Financing, Total Health & Productivity Management, Sutter Health

Sandra Williams, Environment of Care Manager/Safety Officer, Environmental Health and Safety, Alameda Health System

Locations

March 22
Hyatt Regency Sacramento
1209 L Street
Sacramento, CA 95814

March 30
Hilton Orange County/Costa Mesa
3050 Bristol Street
Costa Mesa, CA 92626

Tuition

Member Rate.....**$305**

Tuition includes CEs and lunch.

Members are CHA member hospitals, CHA associate members and government agencies. Education programs and publications are a membership benefit and are not available to eligible nonmember hospitals.

Download Presentations Online Before the Event
You will receive an email before the event with instructions on how to download the presentations to your laptop/tablet for viewing on-site or to print and bring with you. Be sure to download the materials in advance; WiFi access on-site may be limited.

Hospital Employee Safety and Workers' Compensation Seminar

Continuing Education

Full attendance at the educational session is a prerequisite for receiving professional continuing education. Attendees must sign in at the seminar and, when required, include their professional license number. Certificates will be emailed.

Compliance — Application has been made to the Health Care Compliance Certification Board for approval to award Health Care Compliance Association continuing education credit for this seminar.

Health Care Executives — CHA is authorized to award 6 hours of pre-approved ACHE Qualified Education credit for this program toward advancement, or recertification, in the American College of Healthcare Executives. Participants in this program who wish to have the continuing education hours applied toward ACHE Qualified Education credit must self-report their participation. To self-report, participants must log into their MyACHE account and select ACHE Qualified Education Credit.

Nursing — Provider approved by the California Board of Registered Nursing, Provider CEP 11924, for 7.2 Contact Hours.

Risk Management— Application has been made to the American Society of Healthcare Risk Management to award continuing education credit for this program.

Certificates of attendance for self-submission to the provider of your choice are available upon request.

Additional Information

Cancellation Policy/Late Payment: A $50 non-refundable processing fee will be retained for each cancellation. Cancellations must be made in writing seven or more days prior to the scheduled session and emailed to education@calhospital.org. No refunds will be made after these dates. Substitutions are encouraged. Please note: payment is due one day prior to the program. Payments not received by the seminar date may be subject to a 10% late fee.

Special Accommodations or Questions: If you require special accommodations pursuant to the Americans with Disabilities Act, or have other questions, please call (916) 552-7637.

Three Ways to Register

Online: Register at
www.calhospital.org/hospital-employee-safety-workers-comp

Mail: California Hospital Association
Education Department
1215 K Street, Suite 800
Sacramento, CA 95814

Fax: Fax your registration to (916) 552-7506
with credit card information

Register online

This is a one-day seminar; check the location you will attend:

☐ **March 22** Sacramento ☐ **March 30** Costa Mesa

Name:

Title:

Organization:

Address:

City:

State: Zip:

Telephone:

Email: (required)

Cc Email: (optional)

Dietary Request: ☐ Vegetarian Food Allergies:

Special Accommodations Pursuant to ADA:

CEs:

☐ Compliance ☐ Risk Management

☐ Health Care Executives

☐ Nursing (Lic. # required)

Tuition:

☐ Member Rate.....$305

Members are CHA member hospitals, CHA associate members and government agencies. Education programs and publications are a membership benefit and are not available to eligible nonmember hospitals.

Payment:

☐ Check enclosed. Make check payable to CAHHS/CHA and include registrant's name.

☐ Credit Card (check one): ☐ VISA ☐ MC ☐ AMEX

Card Number:

Expiration Date: Security Code:

Cardholder:

Billing Address:

Authorizing Signature:

Questions? Call (916) 552-7637

Labor & Employment Law Seminar

- Significant case law
- Wage and hour in practice
- Background checks and references
- 2016 legislative update

October 19 Sacramento
October 26 Los Angeles

Labor & Employment Law Seminar

Managing HR for hospitals is a bit like playing chess. With all of the pieces in play – including new laws, rules and regulations – hospital employers must strategically develop and implement policies, procedures and programs that encompass these changes and adhere to legal requirements. As with chess, understanding the rules, and knowing when and how to effectively implement them, are key to success.

Make plans to attend and hear the latest updates on important changes impacting your work. CHA's expert lineup will provide information on:

Case Law Developments
The core session of this annual program offers the latest case law updates on a variety of topics, including: calculating overtime, EEOC developments, disability discrimination, class actions and more.

Wage and Hour Compliance in Practice
AWS and meal and rest period compliance continue to plague employers. Plus, hospitals who use contract employees face even greater challenges with expanding joint employer liability. Learn steps you can take now to mitigate liability.

Hiring Considerations
Securing quality employees requires a fair amount of information gathering. Learn what to request in a background check, how and when to use criminal history in hiring decisions, and employer protections when sharing termination information.

Managing the Disruptive Physician
Physician misconduct can lead to huge repercussions for the hospital. Hear methods to engage HR and medical staff in managing allegations of sexual harassment, workplace violence or other disruptive behavior.

Register now for this members-only event.

Who should attend

- **Human resources executives**
- **Employee relations managers**
- **Benefits managers**
- **Payroll specialists**
- **Chief operating officers**
- **Legal counsel**
- **Risk managers**
- **Nursing directors**

This program is for employees of CHA member hospitals only.

"Super presentation as always."

"Focused and summarized recommendations."

"Great tips and practical information."

"Knowledgeable and entertaining — a great combination."

— Comments from 2015 Labor & Employment Law Seminar attendees

Agenda

8:00 – 8:30 a.m. | **Registration/Check-in**

8:30 a.m. – 12:15 p.m.

Wage and Hour Law
- Meal and rest period developments — class certification, timing and combining breaks
- The merger of legislation and litigation in the *Gerard* case
- Paystub compliance — statutory changes and lessons from litigation
- Calculating overtime on bonuses
- Hours worked and time records — rounding and the "de minimis" standard

Wrongful Discharge/Employment Discrimination
- EEOC changes to investigation procedures, subpoena power
- Disability discrimination — is animus required?
- What is associational disability claim?
- FEHC harassment regulations

Grab Bag
- PAGA activity
- Arbitration agreements — class action waivers, preemption, enforceability
- Implications of California Supreme Court "seating" decision

Proactive Steps to Avoid Wage and Hour Pitfalls
- Emerging AWS issues
- Continuing meal and rest periods, and other pitfalls
- Joint employer issues and liability

12:15 – 1:00 p.m. | **Hosted Luncheon**

1:00 – 4:30 p.m.

Hiring Issues — Criminal Background Checks and References
- When and how criminal history can be used in employment decisions
- Background checks — what you may or may not learn about applicants
- Hospital-to-hospital references and protections for employers sharing termination facts

Managing Physician Misconduct
- Reviewing potential areas of liability
- Creating a collaborative process between HR and medical staff
- Protecting employees and your organization

Annual Legislative Update
- 2016 legislation — what passed
- Executive compensation initiative update
- Workplace violence prevention regulations — where we stand now
- FLSA exempt status and implications for CA employers

Faculty

Richard Simmons is a partner in the Los Angeles office of Sheppard Mullin Richter & Hampton, LLP. Mr. Simmons' expertise includes wage and hour law, wrongful discharge, labor relations, employee discipline, arbitration issues and employment discrimination. Mr. Simmons is the author of numerous legal publications for employers, including the *Wage and Hour Manual for California Employers*.

Jeffrey Berman is a partner in the labor and employment practice department at Seyfarth Shaw LLP in Los Angeles. Mr. Berman represents employers in a variety of industries, including the health care industry, with a focus on wage-hour, traditional labor, employment discrimination and sexual harassment cases.

Kerry Friedrichs is a partner in the San Francisco office of Seyfarth Shaw LLP and member of the firm's Labor and Employment department. Ms. Friedrichs' experience includes defense of wage and hour class actions, and employer representation in Department of Labor investigations and claims before the Division of Labor Standards Enforcement.

Kate Kearns is a senior account executive with Universal Background Screening, a leading provider of comprehensive employment background screening solutions. Ms. Kearns has served more than 20 years in the industry as a professional in background screening and is a licensed private investigator.

Muira Mishra is the founder and principal of MKM Law Group, PC. Ms. Mishra provides legal advice to employers in all aspects of employment law and conducts internal investigations, workplace audits and training for executives, managers and employees.

Gail Blanchard-Saiger, is vice president of labor and employment for the California Hospital Association. Ms. Blanchard-Saiger provides leadership for state legislative and regulatory issues related to hospital human resources and labor relations.

Additional faculty to be announced.

Sites

October 19, 2016
Sacramento Convention Center
1400 J Street
Sacramento, CA 95814

October 26, 2016
Los Angeles Airport Marriott
5855 West Century Boulevard
Los Angeles, CA 90045

Tuition

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Member Rate **$305**

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New: Download Presentations Online Before the Event

You will receive an email before the event with instructions on how to download the presentations to your laptop/tablet for viewing on-site, or to print and bring with you. Be sure to download the materials in advance; WiFi access on-site may be limited.

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Full attendance at the educational session is a prerequisite for receiving professional continuing education. Attendees must sign in at the seminar and, when required, include professional license number. Certificates will be emailed.

Health Care Executives — Application has been made to award ACHE Qualified Education credit (non-ACHE) for this program toward advancement or recertification in the American College of Healthcare Executives.

Human Resources — After the program, attendees may submit CHA's Certificate of Attendance to the HR Certification Institute (HRCI) to be considered for HRCI continuing education credit.

Legal — CHA is a State Bar of California approved MCLE provider. This activity has been approved for 6.9 hours of MCLE credit. Provider number 1980.

Nursing — Provider approved by the California Board of Registered Nursing, CEP 11924, for 8.3 Contact Hours.

Additional Information

Cancellation Policy/Late Payment: A $50 non-refundable processing fee will be retained for each cancellation. Cancellations must be emailed seven or more days prior to the scheduled session to education@calhospital.org. No refunds will be made after these dates. Substitutions are encouraged. Please note: Payment is due on or before the program. Payments not received by the seminar date may be subject to a 10% late fee. In the unlikely event the program is cancelled, CHA will fully refund paid participants within 30 days.

Special Accommodations or Questions: If you require special accommodations pursuant to the Americans with Disabilities Act, or have other questions, please call (916) 552-7637.

Three Ways to Register

Register online

Online: www.calhospital.org/labor-employment

Mail: California Hospital Association
Education Department
1215 K Street, Suite 800
Sacramento, CA 95814

Fax: Fax registration to (916) 552-7506
with credit card information

This is a one-day, members-only seminar; check the seminar you will attend:

☐ **October 19** Sacramento ☐ **October 26** Los Angeles

Name:

Title:

Organization:

Address:

City:

State: Zip:

Telephone:

Email: (required)

Cc Email: (optional)

Dietary Request: ☐ Vegetarian

Food Allergies:

CEs:

☐ Health Care Executives

☐ Legal (# required) _____

☐ Nursing (# required) _____

Tuition:

☐ Member Rate $305

Payment:

☐ Check enclosed. Make check payable to CAHHS/CHA and include registrant's name.

☐ Credit Card (check one): ☐ VISA ☐ MC ☐ AMEX

Card Number:

Expiration Date: Security Code:

Cardholder:

Billing Address:

Authorizing Signature:

Questions? Call (916) 552-7637

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 28, 2017

TO: Human Resources Committee

FROM: Gail Blanchard-Saiger, Vice President & Counsel, Labor & Employment

SUBJECT: Emerging Issues

I. ACTION REQUESTED

Discuss emerging topics and identify member support needs, if any.

II. SUMMARY AND BACKGROUND

Various topics have been identified as emerging issues that require attention by hospital human resources executives. See materials attached.

Fair Employment & Housing Council
Additional Modifications to Regulations Regarding Transgender Identity and Expression

CALIFORNIA CODE OF REGULATIONS
Title 2. Administration
Div. 4.1. Department of Fair Employment & Housing
Chapter 5. Fair Employment & Housing Council
Subchapter 2. Discrimination in Employment
Article 5. Sex Discrimination

TEXT

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Text proposed to be deleted for the 45-day comment period is displayed in ~~strikethrough~~ type.
Text proposed to be added for the 15-day comment period is displayed in double underline type.
Text proposed to be deleted for the 15-day comment period is displayed in ~~double strikethrough~~ type.
Text proposed to be added for the second 15-day comment period is displayed in **bold** type.
Text proposed to be deleted for the second 15-day comment period is displayed in *italics* type.
Text proposed to be added for the third 15-day comment period is displayed in wavy underline type.
Text proposed to be deleted for the third 15-day comment period is displayed in dotted underline type.

In some instances, the text currently under consideration may be both single stricken and double underlined, which means it is text that was previously proposed to be deleted from an existing regulation, which the Council has restored and is no longer proposing to delete. Similarly, text that is both single underlined and double stricken means that the text was previously proposed to be added, but the Council subsequently decided to remove it. The same logic applies for text that is bolded/italicized or wavy underlined/dotted underlined as those are the most recent revisions proposed by the Council.

§ 11030. Definitions.

(a) "Facility" includes, but is not limited to, restrooms, locker rooms, dressing rooms, dormitories, and other similar facilities.

(~~a~~b) "Gender expression" means a person's gender-related appearance or behavior, *or* the *perception of such appearance or behavior*, whether or not stereotypically associated with the person's sex assigned at birth.

(~~b~~c) "Gender identity" means ***a*each** person's internal understandingself-identification of their gender, *or* the *perception of a person's gender identitysuch self-identification*, which may include~~as~~ male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.

(~~c~~d) “Sex” has the same definition as provided in Government Code section 12926, which includes, but is not limited to, pregnancy; childbirth; medical conditions related to pregnancy, childbirth, or breast feeding; gender; gender identity; and gender expression, or perception **by a third party** of any of the aforementioned.

(~~d~~e) “Sex Stereotype” *means***includes, but is not limited to,** an assumption about a person’s appearance or behavior, **gender roles, gender expression, or gender identity,** or about an individual’s ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual’s sex.

(~~e~~f) “Transgender” is a general term that refers to a person whose gender identity differs from the person’s sex assigned at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as “transsexual.”

(~~f~~g) “Transitioning” is ~~the~~a *multi-step* process some transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This process may ~~or may not~~ include, but is not limited to, changes in name and pronoun usage, ~~bathroom,~~ facility usage, participation in **employer-sponsored** activities **(e.g.** *like* sports teams**, team-building projects, or volunteering)**, **or undergoing** hormone therapy, ~~sex reassignment~~ surgeries~~,~~, or other medical procedures.

Note: Authority cited: Section 12935(a), Government Code. Reference: Sections 12920, 12921, 12926, 12940, 12943 and 12945, Government Code.

§ 11031. Defenses.

Once employment discrimination on the basis of sex has been established, an employer or other covered entity may prove one or more appropriate affirmative defenses as generally set forth in section 11010, including, but not limited to, the defense of Bona Fide Occupational Qualification (BFOQ).

(a) Among situations that will not justify the application of the BFOQ defense are the following:

(1) A correlation between individuals of one sex and physical agility or strength;

(2) A correlation between individuals of one sex and height;

(3) Customer preference for employees of one sex;

(4) The necessity for providing separate facilities for one sex;~~ or~~

(5) The fact that an individual is transgender or gender non-conforming, or that the individual’s sex assigned at birth is different from the sex required for the job; or

(~~5~~6) The fact that members of one sex have traditionally been hired to perform the particular type of job.

(b) Personal privacy considerations may justify a BFOQ only where:

(1) The job requires an employee to observe other individuals in a state of nudity or to conduct body searches, and

(2) It would be offensive to prevailing social standards to have an individual of a~~the~~ different~~opposite~~ sex present, and

(3) It is detrimental to the mental or physical welfare of individuals being observed or searched to have an individual of a~~the~~ different~~opposite~~ sex present.

(c) Employers or other covered entities shall assign job duties and make adjustments so as to minimize the number of jobs for which sex is a BFOQ.

(d) It is no defense to a complaint of harassment based on sex that the alleged harassing conduct was not motivated by sexual desire.

(e) Employers shall permit employees to perform jobs or duties that correspond to the employee's gender identity or gender expression, regardless of the employee's assigned sex at birth.

Note: Authority cited: Section 12935(a), Government Code. Reference: Sections 12920, 12921, 12940, 12943, and 12945, Government Code.

§ 11034. Terms, Conditions, and Privileges of Employment.

(a) Compensation.

(1) Except as otherwise required or permitted by regulation, an employer or other covered entity shall not base the amount of compensation paid to an employee, in whole or in part, on the employee's sex.

(2) Equal Compensation for Comparable Work. (Reserved.)

(b) Fringe Benefits.

(1) It is unlawful for an employer to condition the availability of fringe benefits upon an employee's sex, including gender identity and gender expression.

(2) Insofar as an employment practice discriminates against one sex, an employer or other covered entity shall not condition the availability of fringe benefits upon whether an employee is a head of household, principal wage earner, secondary wage earner, or of other similar status.

(3) Except *where***as** otherwise required by state law, an employer or other covered entity shall not require unequal employee contributions by similarly situated ~~male and female~~ employees to fringe benefit plans based on the sex of the employee, nor shall different amounts of basic benefits be established under fringe benefit plans for similarly situated ~~male and female~~ employees.

(4) It shall be unlawful for an employer or other covered entity to have a pension or retirement plan that establishes different optional or compulsory retirement ages based on the sex of the employee.

(c) Lines of Progression.

(1) It is unlawful for an employer or other covered entity to designate~~classify~~ a job exclusively for one sex~~as male or female~~ or to maintain separate lines of progression or separate seniority lists based on sex unless it is justified by a permissible defense. For example, a line of progression or seniority system is unlawful that:

(A) Prohibits an individual~~female~~ from applying for a job labeled "male" or "female," or for a job in a "male" or "female" line of progression~~, and vice versa~~; or

(B) Prohibits an employee~~male~~ scheduled for layoff from displacing a less senior employee on a "male" or "female" ~~on a "female"~~ seniority list~~, and vice versa~~.

(2) An employer or other covered entity shall provide equal opportunities to all employees for upward mobility, promotion, and entrance into all jobs for which they are qualified. However, nothing herein shall prevent an employer or other covered entity from implementing mobility programs to accelerate the promotion of underrepresented groups.

(d) Dangers to Health, Safety, or Reproductive Functions.

(1) If working conditions pose a greater danger to the health, safety, or reproductive functions of applicants or employees of one sex than to individuals of ~~the~~ another sex working under the same conditions, the employer or other covered entity shall make reasonable accommodation to:

(A) Alter the working conditions so as to eliminate the greater danger, unless it can be demonstrated that the modification would impose an undue hardship on the employer. Alteration of working conditions includes, but is not limited to, acquisition or modification of equipment or devices and extension of training or education; or

(~~A~~B) Upon the request of an employee of the more endangered sex, transfer the employee to a less hazardous or strenuous position for the duration of the greater danger, unless it can be demonstrated that the transfer would impose an undue hardship on the employer.~~; or~~

~~(B) Alter the working conditions so as to eliminate the greater danger, unless it can be demonstrated that the modification would impose an undue hardship on the employer. Alteration of working conditions includes, but is not limited to, acquisition or modification of equipment or devices and extension of training or education.~~

(2) An employer or other covered entity may require an applicant or employee to provide a physician's certification that the individual~~he or she~~ is endangered by the working conditions.

(3) The existence of a greater risk for employees of one sex than ~~the~~ another sex shall not justify a BFOQ defense.

(4) An employer may not discriminate against members based on~~of one~~ sex because of the prospective application of this subsection.

(5) With regard to protections due on account of pregnancy, childbirth, or related medical conditions, see section 11035.

(6) Nothing in this subsection shall be construed to limit the rights or obligations set forth in Labor Code section 6300 et seq.

(e) Working Conditions.

(1) Where rest periods are provided, equal rest periods must be provided to employees without regard to the sex of the employee~~of both sexes~~.

(2) Equal access to comparable, safe, and adequate ~~toilet~~~~restrooms, locker rooms, dressing rooms, dormitories, and other similar~~ facilities ~~("facilities")~~ shall be provided to employees without regard to the sex of the employee~~of both sexes~~. This requirement shall not be used to justify any discriminatory employment decision.

(A) Employers shall permit employees to use facilities that correspond to the employee's gender identity or gender expression, regardless of the employee's assigned sex at birth.

(B) Employers and other covered entities with single-occupancy facilities under their control shall use gender-neutral signage for those facilities, such as "Restroom," "Unisex," "Gender Neutral," "All Gender Restroom," etc.

(C~~B~~) To respect~~balance~~ the privacy interests of all employees, employers shall provide feasible alternatives ~~if no individual facility is available,~~ such as~~,~~ locking toilet stalls, staggered schedules for showering, shower curtains, or other method of ensuring privacy. However, an employer or other covered entity may not require an employee to use a particular facility.

(D~~C~~) ~~Transitioning e~~Employees shall not be required to undergo, or provide proof of, any *particular* medical treatment or procedure, or provide any identity document, to use facilities designated for use by a particular gender.

~~(D) Employers and other covered entities with single-occupancy facilities under their control shall use gender-neutral signage for those facilities, such as "Restroom," "Unisex," "Gender Neutral," "All Gender Restroom," etc.~~

(E) Notwithstanding subdivision (i)(1)(B) of this section, nothing shall preclude an employer from making a reasonable and confidential inquiry of an employee for the sole purpose of ensuring access to comparable, safe, and adequate multi-user facilities.

(3) Support services and facilities, such as clerical assistance and office space, shall be provided to employees without regard to the employee's sex.

(4) Job duties shall not be assigned according to sex stereotypes.

(5) It is unlawful for an employer or other covered entity to refuse to hire, employ or promote, or to transfer, discharge, dismiss, reduce, suspend, or demote an individual ~~of one sex and not the other~~ on the grounds that the individual is not sterilized or refuses to undergo sterilization.

(6) It shall be lawful for an employer or labor organization to provide or make financial provision for childcare services of a custodial nature for its employees or members who are responsible for the care of their minor children.

(f) Sexual Harassment. Sexual harassment is unlawful as defined in section 11019(b), and includes verbal, physical, and visual harassment, as well as unwanted sexual advances. An employer may be liable for sexual harassment even when the harassing conduct was not motivated by sexual desire. A person alleging sexual harassment is not required to sustain a loss of tangible job benefits in order to establish harassment. Sexually harassing conduct may be either "quid pro quo" or "hostile work environment" sexual harassment:

(1) "Quid pro quo" (Latin for "this for that") sexual harassment is characterized by explicit or implicit conditioning of a job or promotion on an applicant or employee's submission to sexual advances or other conduct based on sex.

(2) Hostile work environment sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interfere with an employee's work performance or create an intimidating, hostile, or offensive work environment.

(A) The harassment must be severe or pervasive such that it alters the conditions of the victim's employment and creates an abusive working environment. A single, unwelcomed act of harassment may be sufficiently severe so as to create an unlawful

hostile work environment. To be unlawful, the harassment must be both subjectively and objectively offensive.

(B) An employer or other covered entity may be liable for sexual harassment even though the offensive conduct has not been directed at the person alleging sexual harassment, regardless of the sex, gender, gender identity, gender expression, or sexual orientation of the perpetrator.

(C) An employer or other covered entity may be liable for sexual harassment committed by a supervisor, coworker, or third party.

1. An employer or other covered entity is strictly liable for the harassing conduct of its agents or supervisors, regardless of whether the employer or other covered entity knew or should have known of the harassment.

2. An employer or other covered entity is liable for harassment of an employee, applicant, or independent contractor, perpetrated by an employee other than an agent or supervisor, if the entity or its agents or supervisors knows or should have known of the harassment and fails to take immediate and appropriate corrective action.

3. An employer or other covered entity is liable for the sexually harassing conduct of nonemployees towards its own employees where the employer, or its agents or supervisors, knows or should have known of the conduct and fails to take immediate and appropriate corrective action.

4. An employee who harasses a co-employee is personally liable for the harassment, regardless of whether the employer knew or should have known of the conduct and/or failed to take appropriate corrective action.

(g) Physical Appearance, Grooming, and Dress Standards. ~~It is lawful for an employer or other covered entity to impose upon an applicant or employee physical appearance, grooming or dress standards that serve a legitimate business purpose, so long as any such standard does not discriminate based on an individual's sex, including gender, gender identity, or gender expression. However, if such a standard discriminates on the basis of sex and if it also significantly burdens the individual in his or her employment, it is unlawful.It is unlawful to require individuals to dress or groom themselves in a manner inconsistent with their gender identity or gender expression.~~It is unlawful to impose upon an applicant or employee any physical appearance, grooming or dress standard which is inconsistent with an individual's gender identity or gender expression, unless the employer can establish business necessity and does not discriminate based on an individual's sex, including gender, gender identity, or gender expression.

(h) Recording of Gender and Name.*(1)* As provided in sections 11016(b)(1) and 11032(b)(2) of these regulations, inquiries that directly or indirectly identify an individual on the basis of It is unlawful to require an applicant ~~or employee~~ to identify the applicant's sex, including gender, gender identity, or gender expression, are unlawful~~state whether the individual is transgender~~

unless the employer establishes a permissible defense. For recordkeeping purposes in accordance with 11013(b), an**An employer may request an applicant to provide this information** solely **on a voluntary basis similar to other protected categories.**

(2**1**) If**, pursuant to a permissible defense or on a voluntary basis,** a job application form **asks***requires* an individual to identify as male or female, designation by the applicant of a gender that is inconsistent with the applicant's assigned sex at birth or presumed gender shall not be considered fraudulent or a misrepresentation for the purpose of adverse action based on the applicant's designation**, unless the employer establishes a permissible defense**.An applicant's designation on an application form of a gender that is inconsistent with the applicant's assigned sex at birth or presumed gender may be considered fraudulent or a misrepresentation for the purpose of an adverse employment action based on the applicant's designation only if the employer establishes a permissible defense.

(3**2**) An employer shall not discriminate against an applicant based on the applicant's failure to designate male or female on an application form, except as noted in subsection (5**4**) below.

(~~3~~4**3**) If an employee requests to be identified with a preferred gender, name, and/or pronoun, including gender-neutral pronouns, an employer or other covered entity who fails to abide by the employee's stated preference may be liable under the Act, except as noted in subsection~~division~~ (~~4~~5**4**) below.

(~~4~~5**4**) An employer **is permitted to***shall*~~may~~ use an employee's gender or legal name as indicated in a government-issued identification document only if it is necessary to meet a legally-mandated obligation**, but otherwise must identify the employee in accordance with the employee's gender identity and preferred name**.

(i) Additional Rights.

(1) It is unlawful for employers and other covered entities to inquire or require documentation or proof of an individual's sex, gender, gender identity, or gender expression as a condition of employment;~~, unless the employer or other covered entity meets its burden of proving a BFOQ defense, as defined above, or the employee initiates communication with the employer regarding any requested adjustment to the employee's working conditions.~~

(A) Nothing in this subsection shall preclude an employer from asserting a BFOQ defense, as defined above

(B) Nothing in this subsection shall preclude an employer and employee from communicating about the employee's sex, gender, gender identity, or gender expression when the employee initiates communication with the employer regarding the employee's working conditions.

(2) It is unlawful to deny employment to an individual based wholly or in part on the individual's sex, gender, gender identity, or gender expression.

(3) Nothing in these regulations shall prevent an applicant or employee from asserting rights under other provisions of the Act, including leave under the California Family Rights Act and rights afforded to individuals with mental or physical disabilities.

(4) It is unlawful to discriminate against an individual who is transitioning, ~~or~~ has transitioned, or is perceived to be transitioning.

Note: Authority cited: Section 12935(a), Government Code. Reference: Sections 12920, 12921 and 12940, Government Code; *Meritor Savings Bank v Vinson* (1986) 477 US 57, 67-68; *Harris v Forklift Systems* (1993) 510 US 17, 23; *Lyle v Warner Bros.* (2006) 38 Cal.4th 264, 273; *Fisher v San Pedro Peninsula Hosp.* (1989) 214 Cal.App.3d 590, 608; *Miller v. Dept. of Corrections* (2005) 36 Cal.4th 446*; U.S. Dept. of Labor's Occupational Safety & Health Admin., https://www/osha.gov/Publications/OSHA3795.pdf*; *Tamara Lusardi, Complainant v. John M. McHugh, Secy, Dept of the Army*, EEOC DOC 0120133395 (April 1, 2015) 2015 WL 1607756.

Behaviors that Undermine a Culture of Safety

Policies and Procedures for Medical Staffs and Medical Groups

A Guideline from California Public Protection & Physician Health, Inc.

Draft distributed on 10-5-16 for comment

Comment period ends on 12-5-16

Comments from all interested parties are welcome. All comments received by 12-5-16 will be reviewed by the workgroup, and consideration will be given to changes and additions to the document. The document will then be circulated again for comment.

Send comments or questions by email to gjara@cppph.org

This document is a draft guideline in development; it has not been adopted by CPPPH or any organization.

This draft is being prepared by a workgroup of California Public Protection & Physician Health (CPPPH). The workgroup is comprised of members of the California Medical Association Organized Medical Staff Section (OMSS), the California Hospital Association's Center for Hospital Medical Executives (CHME), and legal counsel employed by the law firms of Nossaman, LLP and Procopio, Cory, Hargreaves & Savitch LLP. They are serving as individuals and not as representatives of the organizations

Roster of the CPPPH workgroup

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INTRODUCTION

Disruptive behavior in physicians is the stuff of popular culture. You don't have to look further than popular television shows to see how one big personality impacts administration, colleagues, staff and patients.1 A Google search for "difficult doctor" returns over 250 million hits. In our professional lives, however, disruptive behavior, unlike in the made-for-TV dramas, has real-life consequences.

The Joint Commission (TJC) has noted, as have others, that disruptive behaviors may be exhibited by any person working in the healthcare setting and are not unique to physicians. The focus falls on physician behavior, however, because of the disproportionate impact physicians have on patient care and the patient care environment.

A 2004 Institute for Safe Medication Practices survey of more than 2000 health care professionals, 75% of whom were nurses, revealed that intimidating behavior was felt to come most often from physicians and had a negative impact on patient care.2

A 2009 survey of 2,100 doctors and nurses by the American Association for Physician Leadership (formerly the American College of Physician Executives) found that nearly 98% of respondents witnessed behavior problems between doctors and nurses in the past year and 30% witnessed these behaviors weekly.3

It is fair to say that many authorities and many disciplines are wrestling with the topic of disruptive behavior of physicians. The effort is necessary because of its impact on patient safety, organizational culture, regulatory compliance and risk management. It is also necessary in order to help physicians remedy those behaviors that undermine a culture of safety. To side step the issues and avoid engagement with a practitioner whose behavior is raising questions does a disservice to our patients, our colleagues and our profession. It may also do disservice to the physician, because the behavior maybe a signal that he or she is suffering from a condition responsive to treatment.

In 2015, California Public Protection & Physician Health convened a workgroup consisting of physicians who are members of the CMA's Organized Medical Staff Section and the

[1] Wachter, Robert. "Gregory House MD: RIP." USA Today News online, March 12, 2012. http://usatoday30.usatoday.com/news/opinion/forum/story/2012-05-21/house-md-doctors-disruptive-behavior/55118270/1.. (Accessed February 21, 2015)

[2] Institute for Safe Medication Practices. Acute Care ISMP Medication Safety Alert. Intimidation: Practitioners speak up about this unresolved problem. March 11, 2004. http://www.ismp.org/newsletters/acutecare/articles/20040311_2.asp. (Accessed February 22, 2015)

[3] Johnson, C. Bad blood: doctor-nurse behavior problems impact patient care. Physician Executive Journal. November/December 2009. http://acpe.physicianleaders.org/docs/default-source/pej-archives-2009/bad-blood-doctor-nurse-behavior-problems-impact-patient-care.pdf?sfvrsn=8 (Accessed February 15, 2015).

California Hospital Association's Center for Hospital Medical Executives, as well as attorneys from the law firms of Nossaman, LLP and Procopio, Cory, Hargreaves & Savitch LLP to consider the current clinical, administrative and legal context related to disruptive behavior in physicians and to prepare this guideline. It is hoped that this work will prove useful to medical staff leaders and all responsible parties involved in credentialing and peer review issues and will contribute to the establishment of a thoughtful, reference-based approach to this important topic.

STATEMENT OF PURPOSE

This document is intended for those in medical staffs, medical groups, and other entities who have responsibility for decisions related to evaluating a practitioner's behavior and/or compliance with the organization's code of conduct. It is intended to assist them in the identification of policies implementation of procedures for support of professional behavior, and effective maintenance of the culture of safety and professionalism within the medical staff and the medical center.

THE EVIDENCE ON WHICH THIS DOCUMENT IS BASED

The statements or recommendations in this document are the consensus of expert opinion. The document was prepared by a work group comprised of persons who are members of the California Medical Association, the California Hospital Association's Center for Hospital Medical Executives, and California Public Protection & Physician Health, working with attorneys from Nossaman, LLP and Procopio, Cory, Hargreaves & Savitch LLP. The work group members participated as individuals, contributing their experience and expertise to the deliberations, but they did not represent their organizations and the final document is not the official policy of those organizations. The information, statements and recommendations reflected in this document shall not be attributed to any one of the individual Workgroup participants. It is a document from California Public Protection & Physician Health.

The information, statements and recommendations set forth in this document are general in nature, do not constitute legal advice and should not be used as the sole basis for decision- or policy-making or as a substitute for obtaining competent legal counsel.

The information, statements and recommendations contained herein are not entirely inclusive, exclusive or exhaustive of all reasonable methods or approaches. They cannot address the unique circumstances of each situation.

Any use or adaptation of this document must include these disclaimers.

Review and comments are requested from all interested parties. Before the final draft is prepared, all comments will be considered and changes made to the document to incorporate the comments adopted by the Work Group.

After the final document is published, it will be subject to periodic review and revision to incorporate new developments. If the document is revised, it will be circulated for comment again and published with a new date.

DEFINITIONS

Wellbeing Committee

The Joint Commission Standard MS.11.01.01 states "The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes."

To implement the process described by this Standard, medical staffs most frequently establish a committee charged to support personal health and to facilitate rehabilitation rather than discipline. (See CMA "Physician Wellbeing Committees: Guidelines" On-Call Document #5177 [2015].) In accordance with The Joint Commission (TJC) Standard, the committee functions separately from the disciplinary activities of the medical staff and maintains the confidentiality of the physician using its services as long as patient safety is not threatened. Such committees (committees so charged) can have different names in different medical staffs; for the purposes of this paper, they will be referred to as the Wellbeing Committee.

Disruptive Behavior

Definitions of "disruptive behavior" have appeared in publications of several organizations, including The Joint Commission, the Federation of State Medical Boards (FSMB), the California Medical Association (CMA) and the American Medical Association (AMA).

The AMA Opinion 9.0452 issued December 2000 states "Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior." 4

From AMA: "Disruptive behavior means any abusive conduct, including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised."

[4] The American Medical Association. Code of Medical Ethics, Opinion 9.045. Physicians with disruptive behavior. December 2000. www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9045.page. (Accessed February 21, 2015)

In 2009, the AMA created the Model Medical Staff Code of Conduct incorporating its definitions of disruptive, inappropriate and appropriate behaviors.5

The Joint Commission linked behavior and patient safety in its 2008 Sentinel Event Alert, "Behaviors that undermine a culture of safety".6

In its 2008 *Sentinel Event Alert*[1], The Joint Commission noted that "Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities." The *Alert* goes on to say, "Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions." In 2012, TJC simplified the definition of disruptive conduct in the Comprehensive Accreditation Manuals to "behaviors that undermine a culture of safety. "

Definitions are discussed in some detail with amplification of different elements, their interpretations and nuances in these documents:

- Reynolds, N. T. (2012). Disruptive physician behavior: Use and misuse of the label. J Med Regul, 98, 8-19.
- CMA OnCall Document #5101 (2014). Disruptive Behavior Involving Members of the Medical Staff
- Behaviors that undermine a culture of safety, The Joint Commission Sentinel Event Alert, Issue 40, July 9, 2008
- Report of the Council on Ethical and Judicial Affairs 2-A-00, American Medical Association Opinion 9.045, June 2000

The discussion of ACGME Core Competencies can provide a useful background from which to consider the definitions of professional behavior as it is desired and as it is described in an organization's code of conduct. See Appendix A.

As we note in this paper, no single definition can be used as the basis for a response of the medical staff without the medical staff having first made an interpretation of the specifics of the situation, circumstances and conditions. There are circumstances where the demands of a situation result in a person's crossing over the lines of acceptable behavior. Without an assessment of the specifics and surrounding details, it is not possible to determine what constitutes an appropriate medical staff response in each situation. This paper is intended to assist in making those decisions.

[5] Cohen B, Snelson E. Model Medical Staff Code of Conduct. American Medical Association. 2009.

[6] The Joint Commission. Sentinel Event Alert, Issue 40. "Behaviors that undermine a culture of safety". July 9, 2008, www.jointcommission.org/sentinel_event_alert_issue_40_behaviors_that_undermine_a_culture_of_safety. (Accessed February 15, 2015)

For the purposes of this paper, disruptive behavior is defined as a pattern of personal conduct, or even a single instance, deemed by peers to be outside of professional standards and detrimental to a patient, patient's family member, the health care team or the efficient delivery of health care services. The behavior may be physical or verbal; the behaviors may be overt intimidating behaviors (verbal outbursts, physical threats) or passive (refusing to perform functions related to appropriate patent care and patient safety, refusing to return phone calls, using condescending voice intonation). The behavior may or may not have affected patient care and patient safety. The fact that the behavior in question did not result in actual disruption of patient care does not change the fact that it is considered disruptive.

Examples of the various classifications of disruptive behaviors can be found in the next section. These are not exhaustive lists but they are helpful because they represent some of the more common examples.

CONSIDERING DISRUPTIVE BEHAVIOR

In determining what meets the definitions of disruptive behavior, it is essential to keep in mind several "modifiers." For one example, a cultural background may affect the way a person behaves toward or communicates with others, as well as the way the recipient interprets the behavior or the communication. Depending on several factors, including the cultural norm and the common practice of either the speaker or the recipient, there can be important differences between what one person considers a compliment and what another person considers a remark that carries inappropriate implications that may be seductive or demeaning.

It is both the way the behavior is received or perceived by the recipient and the effect it has that can determine whether the behavior is considered "disruptive," requiring a response from the medical staff.

While cultural differences should be taken into account to understand the physician's behavior and to suggest possible remedies, they do not constitute an acceptable or excusable reason for violating the hospital's culture of safety. The hospital has a culture of patient safety and effective care that requires behaviors that do not interfere with the safe and effective delivery of patient care. The hospital has an obligation to inform all members of the medical staff about the hospital's culture of safety and each person's obligation to conform his or her behavior to comply with the hospital's culture, and to make clear the consequences of any failure to do so.

While cultural subtleties should be taken into account, the medical staff should apply the same standard of behavior to all members.

What falls outside the definition of disruptive behavior

It is important to note that there will be instances where the person's conduct is clearly not appropriate behavior, but still does not meet the definition of disruptive. This is particularly true when the issue is a single significant episode or a few mild problematic episodes. Every incident should be noted and considered, but not every incident will rise to the level of requiring a response of the medical staff.

Following up on its Sentinel Event Alert, in 2009 the Joint Commission created a new Leadership Standard (LD.03.01.01).7 The first iteration called on leaders to "develop a code of conduct that defines acceptable, disruptive and inappropriate behaviors." Since 2012, however, the Joint Commission moved away from the language of "disruptive and inappropriate behavior" to "behaviors that undermine a culture of safety." This change was felt necessary to promote clarity and fairness so that the standard would not be interpreted to prohibit physicians from exercising "strong advocacy" to improve patient care, or to label advocacy as disruptive behavior. The final standard is clear that leadership must create and maintain a culture of safety and quality throughout the organization.

What is the distinction between disruptive behavior and whistle blowing?

Activity that looks to some like disruptive behavior may be considered by others to be no more than the expression of legitimate complaints motivated by advocacy for patient care. AMA Opinion 9.0452 emphasizes this point: "… criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior."

All comments, especially those that include complaints, criticisms or statements of concern, should be delivered in a professional manner. But even when they are made in a manner considered disruptive, the merits of the communication should be considered in light of how the delivery of patient care is affected or how the workplace environment is impacted. A complaint[8] should be considered without regard to the manner in which it was made. (See the discussion on the impact of whistleblower statutes in the section on Legal Issues.) However, the form in which the complaint is made cannot be ignored. It is possible for the *manner and/or the form of communication*, independent of the content of the message, to constitute unprofessional conduct. (Emphasis added.)

[7] Joint Commission Perspectives. Volume 32. Issue 1. Leadership Standard Clarified to Address Behaviors that Undermine a Safety Culture. January 2012. http://www.jointcommission.org/assets/1/6/Leadership_standard_behaviors.pdf (Accessed February 21, 2015)

[8] In this document, "complaint" refers to all communication of statements of concern, criticisms, reports of incidents, and such. Use of the word "complaint" is not intended to imply that the communication carries more weight or implication than any another or that it is less than objective.

Therefore, the importance of providing the members of the medical staff with an avenue for communicating information, particularly concerns and complaints, should be emphasized. Medical staffs should not only have in place policies and procedures that establish an appropriate chain of command for physicians to be heard with claims or complaints, the medical staff leaders should also take the steps necessary to assure that members of the medical staff are aware of those avenues and how to use them.

In Appendix B, there is an example of a mechanism for communicating physician concerns.

Examples of Inappropriate Conduct

The purpose of this section is to amplify, with examples, the descriptions of different kinds of behavior that are regarded as inappropriate when they are part of interactions with others in the healthcare setting, whether the other persons are colleagues, other health care professionals, hospital employees, patients and/or other individuals. The following examples are designed as a general discussion and illustrations of common problems;[9] they do not represent an exhaustive list.

Verbal abuse

Verbal abuse is usually in the form of vulgar, profane or demeaning language, screaming, sarcasm or criticism directed at an individual. It is often intimidating to the recipient and can affect the performance of others. For example, the recipient may become hesitant or afraid or unwilling to question or communicate concerns, or to notify or involve either the involved practitioner or others when problems occur. Example: in the fact of verbal abuse, the recipient may fail to call a physician for orders or to describe a deteriorating situation late at night for fear of angering the physician called.

This kind of conduct becomes disruptive at the point where it reaches beyond the bounds of fair professional comment or where it seriously impinges on staff morale.

Non-communication

Refusal to communicate with responsible persons can be extremely disruptive in the patient care setting. It becomes disruptive at the point where important information should be communicated, but is not. Closely related are incomplete or ambiguous communications which have the potential to divert patient care resources into having to devote substantial and unnecessary time obtaining follow-up clarification.

[9] The examples contained herein are taken from the CHA Model Medical Staff Rules 2014-2015, Rule 3, Standards of Conduct, Section 3.2, written by Ann O'Connell of Nossaman LLP on behalf of the California Hospital Association and used with permission of the California Hospital Association.

Refusal to return calls

Refusing to return telephone calls from the facility staff can be another form of the problem. Often this type of behavior is a result of what a practitioner feels are repeated, inappropriate phone calls from the facility's staff. However, unless a phone call is returned, the practitioner cannot know the urgency of the matter. The problem can put patient care in unnecessary jeopardy, or can make matters that were not initially urgent, and needn't have become urgent, become urgent as a result of a refusal to return calls.

Physical contact or sexual comments

Offensive or nonconsensual physical contact, or any conduct, whether blatant or subtle, or any unwelcome comments or contacts of a sexual nature, or comments characterized by sexual overtones are considered sexual harassment, which is both illegal and disruptive.

Property damage

Intentional damage to facility premises or equipment calls for a response of the medical staff.

Threatening behavior

Threats to another's employment or position, or language designed to intimidate a person from performing his or her designated responsibilities or interfering with his or her Wellbeing are generally considered disruptive. Examples include threats of litigation against peer review participants or against persons who report concerns in accordance with established reporting channels, and threats to another's physical or emotional safety or property.

Combative behavior

Combative behavior refers to behavior that challenges, verbally or physically, the legitimate and generally recognized authority or generally recognized lines of professional interaction and communication.

Inappropriate communication

Criticism of the facility, its staff, or one's professional peers outside of official problem solving and peer review channels may be considered inappropriate communication. This includes statements placed in the medical records of patients.

Comments made on social media deserve special caution. Not only are social media considered an inappropriate channel for criticism or negative comments, their use creates the potential for breaches of privacy.

While the desire to avoid inappropriate communication should not stifle free communication, it is important to choose the appropriately constructed channels for the message. Appendix B provides one example.

Failure to comply

A pattern of failure to comply with the bylaws, policies and procedures of the medical staff and the facility can be inadvertent, or it can be willful. A pattern of willful failure to comply with rules becomes disruptive at the point that it places the medical staff or the facility in jeopardy with respect to licensing or accreditation requirements, complying with other applicable laws, or meeting other specific obligations to patients, potential patients and facility staff. Specific examples include:

a. A pattern of failure to provide information or otherwise cooperate in the peer review process (for example, refusing to meet with responsible committee members, refusing to answer reasonable questions relevant to the evaluation of patient care rendered in the facility, especially when coupled with an attitude that the responsible committee has no right to be questioning or examining the matter at hand).

b. A pattern of failure to provide information necessary to process the facility's or a patient's paperwork. The facility, its patients and their families have a right to expect timely and thorough compliance with all requirements of the facility, third party payers, regulators, etc., as necessary to assure smooth functioning of the facility; that includes efforts to assist patients with their efforts to claim the benefits to which they are entitled.

c. Violating confidentiality rules (for example, disclosing confidential peer review information outside the confines of the formal peer review process).This has the effect of undermining the peer review process, and jeopardizing important protections that often serve as inducements to assuring ongoing willingness to participate in peer review activities.

d. A pattern of failure to comply with established protocols and standards, including, but not limited to, utilization review standards. Here, it is recognized that from time to time established protocols and standards may not adequately address a particular circumstance, and deviation is necessary in the best interests of patient care. However, in such circumstances, the member will be expected to account for the deviation, and in appropriate circumstances, to work cooperatively and constructively toward any necessary refinements of protocol or standards so as to avoid unnecessary problems in the future.

e. Refusing to participate in or meet medical staff obligations can be disruptive when it reaches the point that the individual's refusal obstructs or significantly impairs the ability of the medical staff to perform its delegated responsibilities, all of which, in the final analysis, are aimed at facilitating quality patient care.

f. Repeatedly failing to honor or ignoring scheduling policies, or reporting late for scheduled appointments, surgeries, and treatments, resulting in unnecessary delays in or hurrying of patient care services being rendered to any patient of the facility.

LEVELS OF BEHAVIOR THAT ARE DEFINED AS PROBLEMATIC

Definitions do not apply equally to all situations. Some differentiation is needed in order to match the response of the medical staff to the situation(s) observed. The medical staff should be prepared to distinguish among levels of severity and frequency and should have prepared in advance to use graduated responses, matching the level of behavior exhibited. It is suggested that the medical staff employ a pattern of graduated responses because of the potential benefits discussed here and in other publications. See *Guidebook for Managing Disruptive Physician Behavior*, College of Physicians and Surgeons of Ontario and the Ontario Hospital Association, April 2008.

Level 1: A single significant episode or a few mild problematic episodes

Level 2: Multiple significant episodes

Level 3: Multiple significant episodes and failure to respond to interventions

Reports of disruptive behavior, at any level, warrant a response by the medical staff even before any untoward outcome may be identified.

The response of the medical staff should be implementation of the steps described in the medical staff's policies and procedures. The responses should be graduated and should match the situation and circumstances.

RESPONSES OF THE MEDICAL STAFF

The protection of patients, employees, practitioners and other persons at the hospital is the primary concern; however, the orderly operation of the hospital and the health of the practitioner are also important considerations. The health of the practitioner deserves attention because experience has shown that certain individuals who exhibit disruptive and abusive behavior may have underlying medical and psychological issues that affect their behavior, and, if those can be effectively addressed, other forms of action may become unnecessary. It can prove helpful in the long run to make an initial assessment of whether there is an association between a practitioner's health (physical health and/or mental and emotional health) and his/her behavior. The committee or entity of the medical staff responsible for the initial assessment is most appropriately one separate from the disciplinary track (such as a Wellbeing Committee), allowing the next steps to be taken in a pathway separate from discipline when that is reasonably expected to be an effective response. (See the section "the role of the Wellbeing Committee" on page 26.)

There should always be a consideration, first, of whether there is a possibility for a therapeutic intervention that might result in the physician's willingness to modify behavior and to cooperate with monitoring that will document the desired change in behavior. This paper discusses how to pursue that possibility. In such situations, the physician makes a written

agreement to comply with specific requirements. An example of such an agreement is in Appendix E.

Three levels of graduated, graded responses of the medical staff

The response of the medical staff should be graduated and should match the situation and circumstances. The levels of response of the medical staff correspond to the levels of behavior listed above.

A response of the medical staff should be initiated at the first indication of a concern. An early response, appropriate to the situation, can be beneficial to both the physician and the medical staff because it could avoid more stringent approaches and actions that may become necessary if no intervention is made.

The responses are briefly summarized in this section, but are outlined in detail in the *Guidebook for Managing Disruptive Physician Behavior* (April 2008 College of Physicians and Surgeons of Ontario & Ontario Hospital Association.) and should be considered part of this section. Portions of the Guidebook appear, with permission, in Appendix F.

Each level requires several steps of advance planning and preparation on the part of the members of the medical staff.

Level 1: Early Response

In response to the first significant incident, or more than one minor incident, several steps should be taken promptly. It is extremely important to make a prompt response to any incident of significance. Waiting deprives both the physician and the medical staff of the benefits of an early intervention. (“Why didn’t you tell me about this when it happened?”)

After making an assessment of all the information available about the incident(s), the medical staff representatives should first determine the appropriate level of response.

To proceed with a Level 1 response, the medical staff representatives should agree on the specific details of how to conduct an informal discussion with the physician. They should agree on the objectives of the meeting and on a method to insure that all the objectives are met. For example, they will want a method of documenting that the physician understood the importance of the message, was clear about what was expected of him/her, and understood that there would be follow up and further steps taken if necessary.

A meeting time and place should be arranged with the physician, and he/she should be notified of the topic of the meeting.

The physician should have the opportunity to respond to the information the medical staff is considering. The physician should be notified of the information that is being considered and is about to go into his/her medical staff file, and a response should be requested from

him/her within a specified time -- a response within 14 days, for example. If the information being considered is egregious in nature, the response from the physician may be requested sooner than 14 days.

In the meeting with the physician, the medical staff representatives should take care to describe the behaviors seen as problematic in an objective manner and in a way that calls attention to the impact on patient care and the culture of safety. (Note that there should be at least two medical staff representatives meeting with the physician.) They should elicit the views of the physician about the situation(s) in question and maintain an openness to considering that information. They should review the medical staff's expectations for changes in behavior, should discuss alternative behaviors that meet the expectations, and should offer some specific measures that would document the physician's compliance with the code of conduct. All such meetings should be documented in the physician's file in the medical staff office, including the date, the persons in attendance, and what was discussed. (Note that this paragraph is not intended to refer to records kept by a Wellbeing Committee.) A follow up meeting with the physician should be scheduled.

Even with such an early, initial response, the medical staff should be prepared to take whatever action is warranted by the circumstances as they become known. It may be that those conducting the early response will determine that the facts and the circumstances encountered warrant immediate corrective action and determine that the appropriate action is referral to the Medical Executive Committee.

Note that all reports of disruptive behavior, and the documentation of how they were addressed, as well as the practitioner's responses (if any), should be maintained indefinitely by the Medical Staff Office, and be accessible for consideration at any time in the medical staff's official reappointment and peer review activities regarding that practitioner.

Records showing the historical background, or a pattern of behavior, are relevant. Having no record or an incomplete record increases the likelihood that the medical staff will lose access to a body of evidence that includes an old or a recurring issue and that supports a convincing justification for action. There is no time limit or statute of limitations that would make the information unavailable or prevent the medical staff or the physician from taking it into consideration. (Note that this paragraph is not intended to refer to records kept by a Wellbeing Committee.)

If the Level 1 Early Response is a referral to the Wellbeing Committee, the record kept by the medical staff says only that the action was a referral to the Wellbeing Committee. The Wellbeing Committee should keep its own records, and those are not shared with any other committee of the medical staff. The records of the Wellbeing Committee should be minimal but sufficient to provide a historical record. When determining what confidential information to retain in the records of the Wellbeing Committee, keep in mind that such records are subject to subpoena by the Medical Board of California.

The medical staff should be alert to the possibility that there may be a treatable health issue or a personality issue that is contributing to the behavior. If so, referral to the Wellbeing Committee to arrange a comprehensive evaluation should be considered, even as an initial step, or the option should be noted for follow up. For further discussion of when to require a comprehensive evaluation, see notes in the section about Level 2 responses of the medical staff.

If the steps taken in the Level 1 response do not bring the behavior in line with the code of conduct in the appropriate period of time or if there are further reports of problematic behavior, the medical staff response should progress to Level 2, with the understanding that the medical staff should proceed to corrective action at any time it becomes appropriate.

Level 2: Response to multiple significant episodes

The response to several significant incidents should include all of the elements of a Level 1 response plus more specific requirements.

If it has not already been done, referral to the Wellbeing Committee must be considered at this time. The additional steps that may be taken by a Wellbeing Committee include:

- Referral for comprehensive evaluation
- An agreement requiring the physician to get appropriate treatment or assistance, counseling and/or education
- An agreement with the physician to monitor his/her compliance with requirements for changes in behavior, with reports on a specific schedule for a certain period of time. A monitoring agreement offered to the practitioner can make the assistance and support of the medical staff (most usually the Wellbeing Committee) available to the practitioner if the practitioner complies with the requirements in the agreement.

Whether to require a comprehensive evaluation may not be easy to decide immediately. The decision will depend on factors that may not be apparent until there has been further experience with the practitioner.

A quote from the *CPPPH Guidelines for Evaluations of Healthcare Professionals* can be helpful in the consideration of whether there should be a comprehensive evaluation: “It is important to note that the evaluation process is a unique opportunity that should not be squandered. If inadequate evaluation is conducted and an important diagnosis is missed or a wrong diagnosis is made, it is difficult to undo. It is therefore not desirable to take the approach ‘start with the most simple evaluation and proceed to a more complex evaluation.’ It is important to select the most appropriate evaluation from the start.”

The initial assessment is based on the observations of those who interact with the physician about the medical staff’s response to his/her behavior. If the physician’s behavior or history give indications of possible diagnoses such as those named in Appendix D (for example,

what is described in DSM 5 as impulse control disorder or paranoid personality disorder), consideration should be given to requesting a full evaluation by a qualified evaluator who would be asked if therapeutic interventions would be helpful in assisting the physician to bring his/her behavior into line with the medical staff's code of conduct and the culture of safety – the behavior expected of those on the medical staff – and making further action unnecessary.

Evaluations should be conducted following the same guidelines as are followed for evaluations requested for any other reason. See *Evaluations of Healthcare Professionals* (CPPPH 2013) and *Assessing Late Career Practitioners.* (CPPPH 2014) As discussed in those documents, the selection of the evaluator should be made from a list of evaluators who have the qualifications and experience that the Wellbeing Committee (or appropriate medical staff committee) has approved. A report from an evaluator selected by the physician being evaluated, without the approval of the appropriate medical staff committee, is not considered sufficient or appropriate.

Evaluations should not be made by the Wellbeing Committee or any other medical staff committee. The medical staff should arrange for the evaluation to be conducted by qualified clinicians, even though there will be situations and locations where access to appropriate qualified evaluators is limited. In such situations, extra resources should be allocated to securing a reliable and appropriate evaluation. Evaluation by a qualified evaluator is key because the decisions and actions of the Wellbeing Committee and of the medical staff will be influenced by or based on the information gained in an appropriate evaluation.

Remember that the evaluator does not have the traditional physician-patient relationship with the evaluee; the evaluator is not the advocate for the evaluee. The report of the evaluation is made from an objective position, not from the position of advocacy for a patient. The person being evaluated is not the patient or client of the evaluator; the entity requesting the evaluation is the client.

Level 3: Response to multiple significant episodes and failure to respond to interventions

The response to further reports of incidents after a second level intervention has already taken place, or after there has been non-compliance with the requirements of an agreement, should be referral from the Wellbeing Committee to the Medical Executive Committee for action by the medical staff as needed to maintain patient safety and quality of care. Such action may include restriction of privileges or other disciplinary action and reporting to the MBC and the National Practitioner Data Bank (NPDB).

Actions of the Medical Staff

In the face of multiple significant episodes and failure to respond to interventions, the medical staff leadership can choose to proceed to corrective action or can choose to provide another

opportunity for the practitioner to follow a rehabilitative path. A rehabilitative path would include increasing the requirements in the monitoring agreement[10]; instruction to obtain treatment and/or education courses, and/or a leave of absence.[11*] A leave of absence may be used to engage in rehabilitation efforts.

Appendix E shows two samples of agreements for monitoring for behavioral issues. [See also the section on monitoring agreements in the CMA Guidelines for Hospital Medical Staff Wellbeing Committees Policies and Procedures (2015)] The agreements should include criteria to be met before the practitioner resumes the exercise of his/her privileges. The criteria should include the achievement of measurable objectives and should require no recurrences of complaints.

Committee members working with practitioners with these agreements should understand that "relapses" are not uncommon. "Relapses" are not to be ignored: they should be met with timely and appropriate responses. Appropriate responses vary depending on the situation. Plans should be in place for a treatment/monitoring response to a "relapse" in behavior. The usual response is an increase in the requirements for counseling or other intervention, with an increase in the oversight required in the monitoring agreement. "Relapses" in behavior need not be automatic triggers for disciplinary action unless the practitioner refuses to cooperate and refuses to continue with treatment and monitoring.

Corrective action, including summary suspension, when indicated

None of the graduated responses prevents the medical staff from proceeding to corrective action, including immediate action, at any time should it become indicated.

Protection of the health and safety of patients and others directly impacted by the practitioner's behavior, including visitors and hospital employees, should always be the paramount consideration guiding the medical staff's decision-making process. Any time medical staff or hospital representatives believe that failure to take immediate action to summarily suspend or restrict a practitioner's clinical privileges may result in an imminent danger to the health of any individual, summary suspension is permitted under California law (see Bus. & Prof. Code §809.5(a). The provisions of the medical staff bylaws regarding summary suspension, who has the authority to impose the summary action, and the concomitant hearing rights to be afforded the practitioner should be followed.

[10] A monitoring agreement is a requirement usually put in place as part of the medical staff's response to behavior that reaches "Level 2".

[11] A leave of absence could be voluntary but still reportable if it occurs during the pendency of an investigation. Legal counsel should be consulted regarding reportability in all such cases.

CONCERNS THAT ERECT BARRIERS TO APPROPRIATE ACTION OF THE MEDICAL STAFF

Medical staff leaders give a variety of reasons for hesitation to act or for avoiding action. Most frequently mentioned are their lack of information, training, and support, and/or lack of access to resources. Hesitant leaders also refer to their concern that the reaction of the physician might be one that the medical staff cannot appropriately handle with the level of skill, support and resources available to it. Leaders also report apprehension that the physician might take some legal action against the hospital or against them personally.

Without information, training, experience, preparation, and the support of others, -- and without trusted and transparent policies and procedures in place -- most people are reluctant to address an awkward and sensitive situation with another person. This is seen more dramatically within a medical staff because there is also a sense of risk that the response of the physician being addressed will cause some harm to the hospital or the people who speak up.

The physician to be addressed may be considered unapproachable for different reasons. He/she may be a well-respected, admired colleague to whom people feel indebted for one reason or another. He may have contributed substantially to the training and mentoring of many colleagues who are therefore reluctant to change roles and exercise influence with him. She may be the source of a significant number of referrals and therefore income. He may be in a powerful position within the organizational structure and capable of causing disruption or successful retaliation. She may sue.

While it is potentially costly and time consuming for the hospital or the medical staff (and potentially threatening for some individuals) to pursue a complaint, it is also potentially costly for the hospital or the medical staff not to pursue it. Remember that the medical staff is obligated to enforce its code of conduct.

ELEMENTS THAT SHOULD BE IN PLACE TO SUPPORT THE ACTION OF THE MEDICAL STAFF

Policies and procedures regarding complaints

The policies of the medical staff should require adherence to a code of conduct, should require that all medical staff members be treated the same, and should provide for and protect the appropriate level of confidentiality for both the person whose behavior is of concern and for the persons giving information to document the behavior in question.

The policies and procedures of the medical staff should contain provisions specifying how complaints should be made and describing the step-wise process for handling them. All medical staff members and hospital employees should be made aware of the process, and

the handling of all complaints should follow the process established by the medical staff to enable the process to be covered by the protections of Evidence Code §1157.

As the first step, the procedures should require that complaints be made in writing with enough specifics to allow for verification of the information. The policies and procedures should make it clear that the complainant's identity may be revealed at some point during the process.

In an effort to lower perceived barriers to providing information, it may be possible for the medical staff to exercise some discretion to protect the identity of the complainant in the beginning of the process. For example, the procedures may allow for a manager to make the initial report on behalf of another member of the department; however the policies should make clear that the person will have to come forward if requested to do so, and therefore no assurances can be given that the person giving the information can remain anonymous indefinitely.

The policies and procedures should take into account the legitimacy of concern about the potential for retaliation and should be explicit about the enforcement of the steps taken to avoid retaliation. The policies should include an admonition that any effort by the physician to contact the complainant in a way that can be perceived as retaliation would be grounds for disciplinary action.

The procedures should require that the physician be notified in a timely manner. (See the Section on Responses of the Medical Staff, page 14.) Some policies and procedures include a step in which the physician is given the opportunity to enter a response and/or information into his/her medical staff file. Requesting a response from the physician in question early in the process can avoid misunderstandings and future problems.

The procedures for a graded, step-wise response should allow for full attention to and resources for each step in the process and each level of response.

Procedures for raising safety concerns and making complaints

There should be a mechanism and process in place through which physicians or others can express concerns about safety of patient care or make constructive comments or complaints.

The process should be clearly described, including naming those responsible for receiving the information, assessing the information and responding to the complainant.

The process should require that complaints/concerns be made in writing and be signed and dated. The policies and procedures for the process should provide that the information be treated confidentially.

All members of the medical staff should be made aware of the process and how to use it. The medical staff policies should make it clear that members of the medical staff are

expected to use the process to express concerns and/or make complaints and that raising issues of concern outside of that process could be considered unprofessional conduct. [An example of such a mechanism, a “Physician Comment Line”, and policy are in Appendix B, along with comments from the California Hospital Association Counsel.]

Legal counsel involvement

The medical staff legal counsel should contribute to the development of both the policies and the procedures the medical staff committees will follow in implementing the policies. In addition, there should be early consultation with legal counsel experienced in behavioral issues and in medical staff processes. If repeated acts are being addressed (level 2), consultation with experienced legal counsel should be considered before the level 2 response begins.

Organizational structure of the medical staff

The medical staff should include committees charged to carry out the policies and procedures. Adequate staff support should be provided for all the activities of the committees. The committees and the individuals who carry out the policies and procedures should have the full confidence that the medical staff will carry out the policies and procedures as they are written.

Medical staffs within hospital systems that want to share information between or among different medical staffs are well served by having in place specific policies to authorize such information sharing and specific procedures to follow.

Educational efforts

Policies and procedures of the medical staff should provide for orientation, education and training about the code of conduct and the hospital’s culture for those appointed to medical staff committees. There should be regular education directed to the whole medical staff and all personnel in the hospital. Such educational efforts should explain the procedures that will be used when incidents arise and should familiarize medical staff members with the applicable laws, regulations and standards.

Ideally, the training for those who carry out the procedures will also cover methods of communication that have been shown to be effective in engaging the physician in the process.

Resources

The medical staff should assure that sufficient resources are in place to support each of the steps outlined in its policies and procedures. Adequate staff support should be provided for all the activities of the committees.

The committees should be prepared with a list of providers who the committee has determined to be qualified and experienced providers of evaluation for healthcare personnel, appropriate interventions like anger management training, or treatment, as well as for monitoring on-going behavior.

Consideration should be given to providing a stipend or other payment for the time required of the members of the committee who carry out each of the steps described in the procedures.

LEGAL CONSIDERATIONS ON WHICH POLICIES ARE BASED

THE JOINT COMMISSION

Since 2009, The Joint Commission requirements have obligated hospitals to establish a code of conduct for all persons working in the hospital. (LD.03.01.01, E)

On July 9, 2008 the Joint Commission issued a "Sentinel Event Alert" discussing new Leadership Standard LD.03.01.01 and its related Elements of Performance, EP4 and EP5, which became effective January 1, 2009. That Standard required hospital leaders adopt a code of conduct defining disruptive behavior and establishing a process for managing such behavior. The Standard did not itself define disruptive behavior, but the accompanying Sentinel Event Alert stated that such behaviors included ". . . overt acts such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities . . . . Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients."

The Elements of Performance related to the new Leadership Standard mandate that:

> "EP4: Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety
>
> EP5: Leaders create and implement a process for managing behaviors that undermine a culture of safety

E§§ffective July 1, 2012 the Joint Commission revised these Elements of Performance to delete reference to the phrase "disruptive and inappropriate behaviors." The Joint Commission explained that the term "disruptive behavior" can be considered ambiguous and noted that physicians who express strong advocacy for improvements in patient care can be inappropriately characterized as disruptive. Accordingly, the Joint Commission adopted the phrase "behaviors that undermine a culture of safety" in place of "disruptive behavior."

CALIFORNIA LAW: A Brief History

The Joint Commission requirements obligated hospitals to establish a code of conduct for all persons working in the hospital. In California, the process of adopting standards to govern the behavior of medical staff members is the responsibility of the medical staff, which is independently responsible "for policing its member physicians" (Health & Safety Code §1250(a); Cal. Code Regs. tit 22 §70701(a)(1)(F); Bus. & Prof. Code § 2282.5(a)(1)).

The Joint Commission's Sentinel Alert affirms the role of the medical staff, stating that medical staff bylaws regarding physician behavior should be complementary and supportive of policies that are in place for the organization of the non-physician staff. The Sentinel Alert further states that medical staff credentialing standards requiring "interpersonal and communication skills" and "professionalism" be part of the privileging and credentialing process (2011 Joint Commission Standards, Introduction to Standard MS 06.01.03).

The California courts have made clear that disciplinary action predicated upon disruptive behavior may not be "substantively irrational or otherwise unreasonably susceptible to arbitrary or discriminatory application." (*Miller v. Eisenhower Medical Center*, 27 Cal.3d 614 (1980).) For that reason, the California Supreme Court noted in *Miller* that physicians may be disciplined for disruptive or inappropriate behavior only "if there is a sufficient nexus to patient care." (*Id* at 622.)

The *Miller* court found that a bylaw requirement that physicians demonstrate an "ability to work with others" was, of itself, so vague as to be subject to arbitrary and irrational application and that to guard against such inappropriate application the standard must demand a showing that the applicant's inability to work with others is such as to present "a real and substantial danger that patients treated by [the physician] might receive other than appropriate care." The court further noted that physician conduct considered controversial, outspoken and even personally offensive to some hospital colleagues might not have an adverse impact upon the delivery of care.

Later decisions have clarified that finding a nexus between disciplinary action for disruptive behavior and adverse impact on patient care does not require a showing of a particular harm to a patient and that a reasonable assessment of the potential for such harm in the future was sufficient. (*Marmion v. Mercy Hospital and Medical Center*, 145 Cal.App3d 72 (1983))

A California federal court, dealing with a claim of denial of federal due process related to disciplinary action taken at a district hospital, applied a similar standard when it noted that "when the individuals who have been on the receiving end . . . determine . . . that rudeness and/or disruptive behavior has reached a level that potentially compromises care of any patient, that conclusion is generally not susceptible to argument to the contrary." (*Jablonsky v. Sierra Kings Healthcare District*, 798 F. Supp. 2d 1148 (2011).)

THE DUTY TO ACT

Once a medical staff has adopted standards and policies for defining inappropriate behavior, it is obligated to enforce those standards and implement those policies. Consistent with Joint Commission Standard MS11.01.01, requiring the medical staff to implement a process to identify and manage matters of individual health, separate and apart from actions taken for disciplinary purposes, the process for managing disruptive behavior should appropriately include an assessment of whether or not the behavior is reflective of health issues susceptible to rehabilitation. If so, the process for handling the behavior should, in the first instance, attempt to facilitate rehabilitation rather than discipline.

However, whether through rehabilitation efforts or disciplinary action, the medical staff must not ignore disruptive behavior. California law is clear that if the medical staff of a hospital fails to take action against a physician who "provides substandard care or who engages in professional misconduct" the governing body of the hospital acts as a failsafe to ensure that the practitioner is removed from the hospital staff. (*El-Attar v. Hollywood Presbyterian Medical Center*, 56 Cal.4th 976, 993 (2013).

The importance of providing options for rehabilitation is shown in case law. It is well recognized that a medical staff and a hospital's failure to ensure the competency of its medical staff may result in liability to patients (*Hongsathavij v. Queen of Angels Medical Center*, 62 Cal.App.4th 1123 (1998); to other members of the medical staff (*Samuel v. Providence Health Care System – Southern California*, unpublished opinion 2013 WL 6634119, (December 17, 2013)), to non-physician staff members such as nurses (*Fisher v. San Pedro Peninsula Hospital*, 214 Cal.App. 3d590(1989)), and, perhaps, even to the family of the physician whose conduct manifests a need for rehabilitation, if rehabilitation is not provided.

THE IMPACT OF EMPLOYMENT STATUTES

Hospitals, as employers of nursing and support staff, have an obligation to ensure that their employees are provided with a safe workplace, including an environment free from harassment. Under state law, it is unlawful for an employer to harass an employee, or to allow harassment to continue if the employer knew or should have known of harassing conduct and failed to take "immediate and appropriate corrective action." (Govt. Code § 12940, sub d.(j)(1).) In a practical sense, this means that the human resources department of the hospital must promptly investigate a report and take such remedial actions as are available to the hospital. While the hospital may be able to place an *employee* on paid leave and potentially diffuse a problem involving that individual employee, that strategy is not available when the disruptive behavior is on the part of a person who is not an employee -- a physician or practitioner member of the medical staff.

Thus, it becomes obvious that the human resources department of the hospital and the medical staff should find a way to work together promptly and cooperatively to investigate

matters of mutual concern created by the disruptive behavior. Such cooperative conduct presents its own set of challenges, including the need to maintain the protection of peer-review information pursuant to Evidence Code §1157.

To avoid conflict between the hospital administration and the medical staff about the responses to allegations of disruptive behavior, compatible policies and procedures should be in place for both the administration / human resources department and the medical staff.

Because the first step in response to reports of inappropriate behavior is to gather and assess information (to investigate), the policies and procedures should describe investigations that are conducted jointly and cooperatively, meeting the needs of both hospital administration and medical staff. The sequence in which the steps are begun and are implemented can be or become a critical factor; therefore the procedures should describe the sequence to be followed.

In order to preserve the protections of Evidence Code §1157, the procedures should specify that the steps are taken by and for the medical staff (under the umbrella of the medical staff) even though they may be taken jointly and cooperatively between the hospital administration and the medical staff. The policy should recognize the protections afforded by Evidence Code §1157 and all procedures should be designed to maintain the peer review confidentiality and non-discoverability under Evidence Code §1157.

Procedures should describe steps to be taken and the sequence in which they should be taken. For example,

1) Notify the chief of staff;
2) Hospital administration and medical staff agree on a process and schedule;
3) Identify all witnesses who should be interviewed;
4) Hospital administration and medical staff agree on who should interview each witness;
5) Creation of findings of fact; and
6) Description of who is entitled to receive findings

The procedures should describe all steps discussed in the section of this paper, “Responses of the Medical Staff.”

LIMITATION OF PRIVILEGES/SUMMARY SUSPENSION

It may well be that the only mechanism available to achieve the prompt insulation of hospital employees from an unsafe work environment created by physician conduct is to remove the physician from the setting. Policies and procedures should provide for mechanisms (for example, medical leave in appropriate circumstances) that can be offered to the physician and implemented immediately using a non-adversarial approach. Advice of medical staff

legal counsel should be sought regarding whether voluntary limitation of access to a hospital unit or limitation of privileges under the circumstances, including a leave of absence, must be reported to the Medical Board of California and National Practitioner Data Bank.

When the physician does not voluntarily take acceptable actions to address the problem, summary suspension may be necessary to protect the patient, hospital employee or other individual from harm. When this is the case, the provisions of the medical staff bylaws regarding summary suspension, who has the authority to impose the summary action and the concomitant hearing rights to be afforded the practitioner should be followed.

Such procedures should be a step-wise progression that allows for disciplinary action to be taken but reserves it for use only if the non-adversarial steps have failed. Summary suspension should not be the only mechanism available to remove the practitioner from the workplace immediately.

THE IMPACT OF THE WHISTLEBLOWER STATUTES

The courts have long recognized the value of physician advocacy as a part of the quality assurance process. As noted in *Rosner v. Eden Township Hospital*, 58 Cal.2d 592 (1962) "the goal of providing high standards of medical care requires that physicians be permitted to assert their views when they feel that treatment of patients is improper or that negligent hospital practices are being followed." It was out of such recognition that California's whistleblower statutes protecting physicians (Bus. & Prof. Code §2056 and Health & Saf. Code §1278.5) were enacted to prevent retaliation against physicians who advocate for medically appropriate care.

A physician facing reports of disruptive and inappropriate conduct may claim that his or her actions were motivated by advocacy for patient care and therefore should not be considered disruptive. The physician may contend that any effort toward discipline constitutes retaliation and may institute a legal action against the hospital based upon that claim. Retaliation is prohibited; the complaining physician has legal protections against retaliation.

It is important to remember that actions of a medical staff member could be both an expression of concern about safety issues *and* disruptive or unprofessional behavior. Legitimate concerns can be expressed in disruptive ways. The fact that the information may be a legitimate expression related to patient safety does not eliminate the need to respond to the disruptive behavior. All complaints and comments about quality of care and patient safety should be assessed independently from the manner in which they are made or expressed. The medical staff should assess and respond to the behavior as well as the safety issue that is raised.

In light of the California Supreme Court in *Fahlen v. Sutter Central Valley Hospitals*, 58 Cal.4th 655 (2014), which determined that a physician did not need to exhaust all available judicial remedies to overturn disciplinary action before pursuing a whistleblower claim

pursuant to Health & Safety Code § 1278.5, the prospect clearly exists that the medical staff and hospital attempting to respond to a physician's disruptive and inappropriate conduct may have to contend with the physician's legal action asserting retaliation.

Medical staffs and hospital administration should have mechanisms in place for receiving and responding to complaints. Policies and procedures should define how the complaints are assessed and how responses are made to the complainant. Having such policies and procedures in place and routinely used, with examples of outcomes that have been deemed successful, is an important element in the maintenance of a culture of safety, protection of patients and staff, and fair treatment of the involved practitioner.

THE ROLE OF THE WELLBEING COMMITTEE

Experience shows that certain individuals who exhibit disruptive and abusive behavior have medical and/or psychological conditions or issues that may affect their behavior. If those can be effectively addressed, other forms of action may become unnecessary, and the medical staff's process *must* provide for such a possibility. (TJC Standard MS 11.01.01)

An evaluation should be considered at the outset so that, in situations where it is possible, professional assistance, with requirements for modification of behavior, can be the first intervention used by the medical staff, and disciplinary action can be employed only if it becomes necessary. The Wellbeing Committee is best positioned to handle these steps because its charge and function are outside the disciplinary process. The recommendations and actions of the Wellbeing Committee can assist the physician through steps that may include a referral, monitoring over time of his/her compliance with agreements to function within the code of conduct and to maintain behavior and interactions that do not interfere with the culture of safety. In such a case, there could be no need for disciplinary action.

Such a non-disciplinary and rehabilitative avenue should be considered early on because if it can be pursued successfully, it could avoid time consuming and costly adversarial situations and could prevent avoidable harm to a physician's career.

REASONABLE ACCOMMODATION

A rehabilitative approach may involve offering a reasonable accommodation, such as a reduction in clinical responsibilities, in response to the physician's situation. If the physician accepts the offer of the accommodation and requests a reduction in his/her privileges, the reduction would not be due to a medical disciplinary cause or reason. A narrowing of a physician's scope of practice as a part of a rehabilitative effort would be characterized as an appropriate and acceptable accommodation of a disability and not a restriction of privileges; reporting to the Medical Board of California or the National Practitioner Data Bank would not be required.

In contrast, as will be discussed more fully below, if the physician does not make his/her own request for a change in his/her privileges and one must be imposed, reporting to the Medical Board of California or the National Practitioner Data Bank would be required. Any restriction that is imposed on the physician's privileges for "medical disciplinary cause or reason" is reportable to the Medical Board of California (*Sahlolbei v. Providence Healthcare*, 112 Cal.App.4th 1137 (2003), and to the National Practitioner Data Bank (*Leal v. DHHS*, 620 F.3d 1280 (2010).)

REPORTING TO THE MBC AND THE NPDB

It is important for all involved to share the same information and understanding of what is to be reported to the Medical Board of California and to the National Practitioner Data Bank. In particular, it is important for a Wellbeing Committee to understand the concepts of reportability to the Medical Board of California and the National Practitioner Data Bank so as to avoid inadvertently creating a reportable event that could have regrettable consequences to the physician and the medical staff or medical group involved.

Business and Professions Code § 805(a)(6) defines "medical disciplinary cause or reason" as "that aspect of a licensee's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care". Business and Professions Code Section 805(B) defines a "peer review body", pertinent part, as "(iv) a committee…that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity". Restrictions imposed by a peer review body for medical disciplinary cause or reasons are reportable to the Medical Board of California.

A Wellbeing Committee should not be so charged, or given such duties, that the Committee would be viewed as having the responsibility or authority to take actions or make recommendations to limit or restrict medical staff privileges based upon an evaluation of the quality of professional care provided by a medical staff member.

Thus, a Wellbeing Committee should not take actions that can be construed as restricting or imposing limitations upon a medical staff member for the purpose of protecting patient safety or the delivery of patient care. In other words, it should not take actions for "medical disciplinary cause or reason." Rather, a Wellbeing Committee should act independently to determine whether a physician requires rehabilitation and to create and implement rehabilitation programs, even if such rehabilitative terms include a cessation or a limitation of practice that is voluntarily undertaken by the medical staff member. The medical staff member should voluntarily request the services of the Wellbeing Committee and it should be clear to the medical staff member that the request is his/her choice.

The actions of the Wellbeing Committee should be taken in pursuit of the rehabilitative objective for the physician in question. The evaluation and rehabilitation activities of the

Wellbeing Committee do not meet the definition of actions based on competence or conduct and should not trigger a reporting obligation.

If the Wellbeing Committee acts otherwise -- for example, responds to a directive from the Medical Executive Committee to oversee an evaluation of a physician *for the purpose of determining whether or not the Medical Executive Committee should take a formal action to impose restrictions upon the physician to protect patient safety and the delivery of patient care [emphasis added]* -- the Wellbeing Committee may well be seen as an arm of the Medical Executive Committee and, therefore, seen as functioning as a peer review body. The evaluation performed would likely be viewed as an investigation and a recommendation of restriction of privileges would likely be viewed as action taken for medical disciplinary cause or reason.

The analysis is similar to that of the National Practitioner Data Bank. However, the NPDB 2015 guidelines describe a more expansive view of what should be considered an "investigation".

See the NPDB e-guidebook: https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp. Under Chapter E: Reports, Reporting Clinical Privilege Actions, the term "Investigations" is discussed*.

The importance of taking every step available to distinguish the rehabilitative activities of the Wellbeing Committee from actions taken by peer review bodies for medical disciplinary cause or reason cannot be overstated. In order for the Wellbeing Committee to be effective in its role as TJC defined it and as medical staffs value it for the ability to resolve situations effectively with the least amount of disruption (and expense), members of the medical staff should have confidence that their request for assistance and the elements of the assistance they receive will be treated confidentially.

SUGGESTED BYLAW PROVISIONS

The California Hospital Association and the California Medical Association each address standards of conduct in their model medical staff bylaws. (See CHA's *Model Medical Staff Bylaws & Rules [2014],* and CMA *Annotated Model Medical Staff Bylaws* [2016])

RESTATEMENT OF PURPOSE

All of the steps associated with implementing the code of conduct have the potential to contribute positively to the safety and quality of patient care as well as to the best interests of the individual practitioner. This document has been prepared as a reference and guide to assist all parties in the process—the individual practitioner and those who prepare, adopt,

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implement, comply with, and defend policies and procedures. The contents of this document do not replace the judgment of the responsible parties applied to individual circumstances.

REFERENCES

California Medical Association OnCall Document #5177 (2015) *Physician Wellbeing Committees: Guidelines*

California Medical Association OnCall Document #5101 (2014). *Disruptive Behavior Involving Members of the Medical Staff*

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WORKGROUP

This document was prepared by a work group comprised of persons who are members of the California Medical Association, the California Hospital Association's Center for Healthcare Medical Executives, and California Public Protection & Physician Health, working with attorneys from Nossaman, LLP, and Procopio, Cory, Hargreaves & Savitch LLP.

The work group members participated as individuals, contributing their experience and expertise to the deliberations, but they did not represent their organizations and the final document is not the official policy of those organizations. It is a document from California Public Protection & Physician Health.

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Ms. Antoine has over three decades of legal experience in the healthcare industry with a previous career as a registered nurse. She represents managed care plans, hospitals and health facilities as well as physicians and physicians' groups on a wide range of regulatory, contracting and licensing issues. She has done peer review work since 1984, and continues to provide representation to individual physicians and medical staffs on peer review hearing matters on a daily basis. She advises on peer review investigations, hearings and other disciplinary actions, bylaws, rules and regulations, Joint Commission compliance and compliance with state and federal laws, and patient care issues. Ms. Antoine was chosen for individual recognition in California Healthcare by the international firm Chambers and Partners, 2014-2016, and is AV Preeminent® Peer Review Rated by Martindale-Hubbell.

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Dr. Nelson practices family medicine in Chico, California and, since 2005, serves as Enloe Medical Center's Vice President for Medical Affairs where her work focuses on physician leadership and quality. She is a member of the California Hospital Association's Center for Healthcare Medical Executives. Her roles at Enloe have included Chief of Staff, Chair of

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Gainer Pillsbury, MD

Dr. Pillsbury was in the private practice of Ob/Gyn for 40 years in Long Beach. During that time he assumed hospital leadership roles as Chief of Staff of Women's Hospital and as a member of the Board of Directors of Memorial Hospital, of Memorial Health Services and the MemorialCare Physician Society. In 1996, he took the position of Medical Director at Long Beach Memorial and was the Chief Medical Officer from 2001-2013. He was a hospital surveyor for the CMA and the Joint Commission for 6 years and has been the Chair of the Physician's Advisory Committee for Hospital Association of Southern California (HASC) and of the California Hospital Quality Committee. He currently is a member of the California Hospital Association's Center for Healthcare Medical Executives.

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Dr. Reynolds has a psychiatric practice in San Jose specializing in evaluations and brings over twenty-five years' experience of performing comprehensive fitness-for-duty assessments, starting well before the term "fitness for duty" came into existence. He is author of the key article, "Disruptive Physician Behavior: Use and Misuse of the Label" published in the *Journal of Medical Regulation*. For the Federation of State Medical Boards, he served as Vice-Chair of the group that developed the FSMB "Policy on Physician Impairment." He is an active contributor to the projects of California Public Protection & Physician Health.

Geoffrey Stiles, MD

Dr. Stiles, Sharp Memorial Hospital, San Diego, serves on the Sharp HealthCare Board of Directors and the Board subcommittees on Quality, Information Technology and Litigation. He is active in Medical Staff governance and served as Chief of Staff in 2004. He subsequently became Medical Director of Quality then Chief Medical Officer while still maintaining a general surgery private practice. He is a member of the California Hospital Association's Center for Healthcare Medical Executives.

James Wells, MD

Dr. Wells served as Chief of Staff, Long Beach Memorial Medical Center, 2011-2015 and a member of the CMA's Organized Medical Staff Section. He was LBMMC, 2009-2015; Past President American Society of Plastic Surgeons, 2002-2003; Past President California Society of Plastic Surgeons,2001-2002; Board of Directors, LBMMC, 2001-2009, 2016-2019; BOD, Memorial Medical Center Foundation, 2016-2019; Director, American Board of Plastic Surgery, 2007-2013; member CMA, AMA, ACS; Program Director, UCI Plastic Surgery at LBMMC, 2001-2015; faculty, The Johns Hopkins Hospital,1975-1979; Senior Medical Officer, USS Midway, 1971-1973. He retired after 41 years of practice of plastic surgery.

APPENDIX A: ACGME CORE COMPETENCIES ADDRESS BEHAVIOR

Definitions from the Accreditation Council on Graduate Medical Education (ACGME)

Patient Care: Identify, respect, and care about patients' differences, values, preferences, and expressed needs; listen to, clearly inform, communicate with and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.

Medical Knowledge: Established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of knowledge to patient care.

Practice-Based Learning and Improvement: Involves investigation and evaluation of one's own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. *Additional documentation is required to be awarded AMA PRA Category 1 Credit™ for this ACGME core competency.*

Interpersonal and Communication Skills: That result in effective information exchange and teaming with patients, their families and other health professionals.

Professionalism: Commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.

Systems-Based Practice: Actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Description and Discussion

This further description and discussion is from the website of Stanford School of Medicine.[12]

The Accreditation Council for Graduate Medical Education (ACGME) expects residents to obtain competency in the following six areas to the level expected of a new practitioner:

Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

[12] http://med.stanford.edu/gme/current_residents/corecomp.html (accessed 5-7-15)

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- communicate effectively with physicians, other health professionals, and health related agencies;
- work effectively as a member or leader of a health care team or other professional group;
- act in a consultative role to other physicians and health professionals; and,
- maintain comprehensive, timely, and legible medical records, if applicable.

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society and the profession; and,
- sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Practice-Based Learning and Improvement (PBLI)

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- identify strengths, deficiencies, and limits in one's knowledge and expertise (self-assessment and reflection);
- set learning and improvement goals;
- identify and perform appropriate learning activities;
- systematically analyze practice using quality improvement (QI) methods, and implement changes with the goal of practice improvement;
- incorporate formative evaluation feedback into daily practice;
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems (evidence-based medicine);
- use information technology to optimize learning; and,
- participate in the education of patients, families, students, residents and other health professionals.

Systems-Based Practice (SBP)

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- coordinate patient care within the health care system relevant to their clinical specialty;
- incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- advocate for quality patient care and optimal patient care systems;
- work in interprofessional teams to enhance patient safety and improve patient care quality; and
- participate in identifying system errors and implementing potential systems solutions.

APPENDIX B: MECHANISMS FOR COMMUNICATING PHYSICIAN CONCERNS

From California Hospital Association

This section is an excerpt from "California's "Whistleblower Protection" Law – For Better or For Worse, It Is What It Is…Recommendations for Coping with Competing Public Interests" distributed 2-26-14 and used with permission from the California Hospital Association.

While registering a complaint with specified responsible individuals (perhaps different individuals depending on the issues involved) is generally the preferred approach, these measures should include a means for registering an anonymous complaint. Although written complaints are clearly preferable, verbal complaints to a recorded "hotline" should also be accepted. The means for registering the complaint should be clearly communicated – including posting in prominent locations throughout the hospital, providing information in hospital and/or medical staff newsletters, and having information about how to register a grievance or complaint clearly accessible via a secure location on the facility's web-site.

The complaints should be "logged," and if contact information has been provided, there should be a communication back to the complainant confirming receipt of the complaint, and formally restating what the facility understands to be the gravamen of the complaint.

Processing the Complaint

An individual should be assigned to evaluate and investigate the complaint. If the complaint involves the performance of an individual or a particular group within the hospital, that individual or group should not be the person or body assigned to investigate the complaint.

Depending on the nature of the complaint, hospital risk management and appropriate medical staff committees may need to be notified. Consideration should be given to whether a Hospital Ombudsman position might lend an appropriate measure of objectivity to the process.

The hospital should clearly document which individuals or bodies are involved in resolution of the complaint, as well as which individuals/bodies are notified of it. This latter step may prove especially important in monitoring and managing potential claims of retaliation.

Responding to the Complaint

The facility needs to determine whether and how much to communicate with the complainant as to the resolution of the complaint. This is a judgment call not unlike that routinely faced by hospitals dealing, for example, with their formal patient grievance system. Generally speaking, details of individual personnel actions are confidential and would not be communicated; however, generic information at least assuring that the issue has been addressed, and perhaps providing general information about how the problem has been

addressed – e.g., implementation of new policies and procedures, and the like – together with a request that the complainant advise if there are any further/future occurrences suggesting the resolution has not been complete – are all strongly recommended.

Documentation

Each step of the grievance/complaint process should be clearly documented. Written complaints should be maintained; verbal complaints coming into a hotline should be transcribed; in-person verbal complaints should be placed into a memo, with a copy to the complaining individual, so that person has an opportunity to correct or clarify the nature of the complaint; investigatory steps should be memorialized; and resolutions should be clearly documented. Of utmost importance, all communications with the complainant should be carefully documented.

EXAMPLE of A MECHANISM FOR COMMUNICATING PHYSICIAN CONCERNS: A PHYSICIAN COMMENT LINE[13]

PURPOSE:

To capture physician concerns and suggestions regarding hospital processes, facilitate problem solving, and improve physician satisfaction with their practices at Enloe. A priority of the system is rapidly communicating a meaningful response to the comments while tracking, reporting, and ensuring resolution of concerns, and then changing systems to prevent recurrences.

PROCEDURE:

The Physician Comment Line is directly managed by the Quality Management Department, with oversight provided by the Vice President of Medical Affairs (VPMA) and the Performance Improvement/ Patient Safety (PIPS) Committee.

A physician will call extension xxx to dictate comments to a secure line. Medical Records personnel will transcribe these comments and send them electronically to the Quality Management Department. If comments are shared via email or verbally, the recipient will forward or transcribe/forward the comments to the Quality Management Department.

The Quality Management Department support staff will integrate the comment into the Midas system.

The Quality Management Manager or Director of Quality Management will review and categorize the comment, then forward it to the appropriate manager for action/resolution.

Within one week the Quality Management Manager or Director of Quality Management will contact the physician to notify him/her that the comment has been received and to which manager it was forwarded.

The manager will contact the physician as soon as possible to discuss the comment.

Within two weeks, the manager will document action and/ or resolution, or reason for non-resolution in the Database, but will not close the entry.

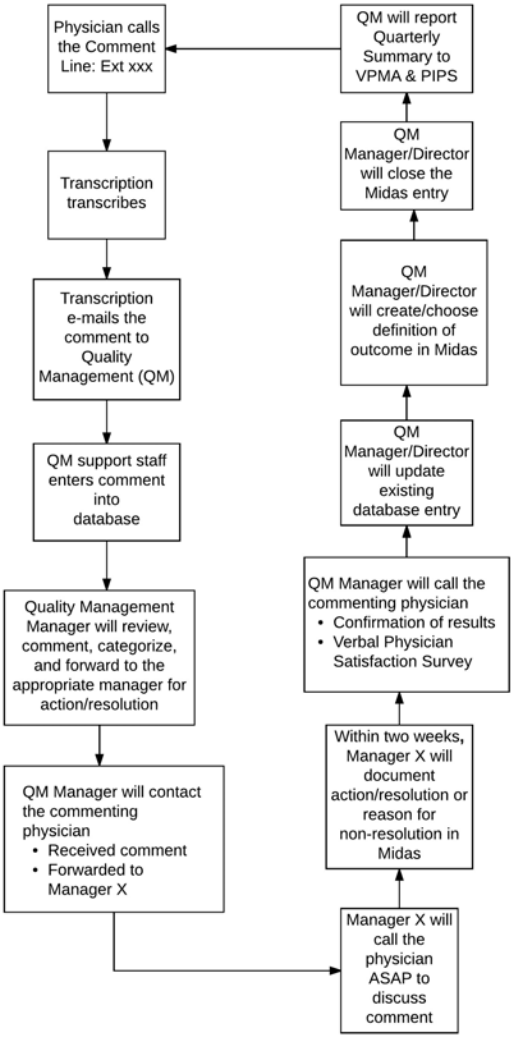
The Quality Management Manager or Director of Quality Management will call the commenting physician, after the manager has entered the response into the databse, to confirm the response and query the physician about his/her satisfaction with the response.

The Quality Management Manager or Director of Quality Management will update the entry and will create/choose the definition of the outcome.

[13] Used with permission from Enloe Medical Center, Chico, CA.

The Quality Management Manager or Director of Quality Management will close the database entry.

Quarterly, Quality Management will report a summary of service and content to the Performance Improvement /Patient Safety Committee.



APPENDIX C: SAMPLE CODES OF CONDUCT

Sample #1 from Long Beach Memorial Medical Center Medical Staff Policies

Code Of Conduct

As a member of the medical staff of Long Beach Memorial Medical Center (LBMMC) and/or Miller Children's Hospital (MCH) or as a non-hospital employed Allied Health Professional (AHP), I acknowledge that the ability of practitioners, AHP's and hospital staff employees to jointly deliver high quality health care greatly depends upon their ability to communicate well, collaborate effectively, and work as a team. I recognize that patients, family members, visitors, colleagues and hospital staff members must be treated in a dignified and respectful manner at all times. To this end, practitioners on the medical staff of LBMMC/MCH and non-hospital employed AHP's practicing at LBMMC/MCH are expected to conduct themselves in a professional manner whenever they are on the grounds of the medical center. I agree to adhere to the following guidelines in support of enhancing the delivery of quality patient care within LBMMC/MCH.

I. Respectful Treatment

I agree to treat patients, family members, visitors and members of the health care team of LBMMC/MCH in a respectful and dignified manner at all times. I acknowledge that my language, attitude and appearance, directly impact delivery of quality patient care. I agree to work with other members of the health care team to resolve conflicts or address occasional lapses of decorum when they arise.

II. Language

I will avoid the use of language that is either written or spoken that is inappropriate, profane, vulgar, sexually suggestive or explicit, intimidating, degrading, or racially/ethnically/religiously slurring in any professional setting on the grounds of the medical center.

III. Behavior

I agree to refrain from any behavior that is deemed to be intimidating or harassing, including but not limited to, unwanted touching, sexually-oriented or degrading jokes or comments, obscene gestures, or throwing of objects. When engaged in patient care responsibilities within the hospital or when serving in any on-call capacity, I agree to not be impaired by the use of alcohol, prescription medications or illegal substances.

IV. Confidentiality & Feedback

I agree to maintain complete confidentiality of patient care information at all times. I further recognize that practitioners, AHPs and hospital staff may occasionally have certain personal concerns regarding one another's performance and competence. When questions of performance or competence arise, I agree to report my concerns to the individual(s) or committees(s) authorized to receive such information and address these issues. I agree to

participate with my colleagues and hospital staff members in resolving issues whenever possible. I recognize the necessity of describing offensive or abusive behavior in objective, non-threatening terms, and will avoid stating conclusions about motives, etc.

V. Ethical Responsibility

I agree to be truthful and forthright in the provision of any and all information I bring forward to the best of my ability.

I acknowledge that I have received and read this "Practitioners/AHP Code of Conduct". I agree to make best efforts to adhere to these guidelines and conduct myself in a professional manner. I further understand that failure to conduct myself in a professional fashion may result in disciplinary action as determined by the Medical Executive Committee pursuant to the Medical Staff Bylaws.

Signature: _____ Date: _____

Policy For Failure To Comply With The Code Of Conduct

Failure to adhere to the guidelines described in the Practitioners and Allied Health Professionals (AHP's) Code of Conduct can be disruptive and may decrease effective communication between members of the healthcare teams. This may interfere with the ability of practitioners, AHP's and staff to provide the highest levels of patient care and safety. For that reason, the following policy has been developed to evaluate non-compliance to the Code of Conduct. All issues will be addressed in a non-biased confidential manner and appropriate actions will be taken emphasizing educational opportunities to improve communication skills to increase physician and staff satisfaction. Disciplinary action will only be considered if educational efforts fail and inappropriate behavior continues.

Any practitioner, AHP, employee, patient or visitor may report behavior that they feel is inappropriate. The report must be in writing, signed and forwarded to the Chief Medical Officer (CMO) or his/her designee and should contain the following information:

- The date and time of the alleged behavior
- If the behavior involved a patient in any way, the name of the patient
- If the behavior involved an employee, the employee's name and supervisor's name
- A description of the event limited to factual, objective language as much as possible. Conclusions about motives, etc., should be avoided.
- The consequences, if any, of the alleged behavior as it relates to patient care or hospital operations
- Any action taken to remedy the situation including the date, time, place, and names of those intervening

Once received, the report will be evaluated by the Chief Medical Officer. Reports that are determined after investigation to be not credible will be dismissed by the CMO and treated as

a non-event. Confirmed complaints which are felt to be of minimal concern will evaluated by the appropriate Chief Medical Officer and/or the appropriate Department/Section Chair and attempts made to bring about conflict resolution in order to preserve mutual cooperation and understanding as a valuable long term asset. Reports of a potentially more serious nature which have been corroborated and verified will be addressed as follows:

1) Even a single egregious incident such as assault, sexual harassment, stealing, throwing equipment or records may result in immediate disciplinary action including summary suspension pursuant to the medical staff bylaws.

2) Alleged inappropriate behavior of a lesser magnitude will be handled in the following manner and any disciplinary action taken will be progressive in nature. Documentation of such actions will be kept in the practitioner's or AHP's peer review file and shall include not only the allegations and results of the evaluation, but any comments or explanations by the practitioner or AHP.

3) A single confirmed incident warrants a discussion with the accused practitioner or AHP after the practitioner or AHP has been informed of the complaint. The CMO or his/her designee shall initiate such a discussion which should be collegial and designed to be helpful to the practitioner or AHP and the hospital staff. The accused practitioner or AHP will be given an opportunity to explain his or her version of the incident. If the practitioner or AHP admits to the behavior in question or if it is corroborated and verified by factual and impartial documentation it will be emphasized to the practitioner or AHP that such conduct is inappropriate and must not happen again. A follow-up letter will be included in the practitioner's or AHP's peer review file along with any rebuttals or explanations by the practitioner or AHP.

4) A second episode corroborated and confirmed by factual documentation within a 2-year time frame from the first incident will require evaluation by the Department/Section Chair and/or the Chief of Staff. The LBMMC/MCH Human Resources Department may need to be informed and included if a medical center employee is involved The Department Chair and/or the Chief of Staff will meet with the practitioner or AHP to discuss the situation and hear his/her version of the incident. If the practitioner or AHP admits to the behavior in question, or if it has been corroborated and verified by factual and impartial documentation, the practitioner will be informed that there is concern that a pattern of unacceptable behavior may be developing. The practitioner or AHP will be informed that this inappropriate behavior must stop. A follow-up letter to the practitioner or AHP will emphasize the requirement to behave professionally within the medical center. This letter will be included in the practitioner's or AHP's peer review file along with any rebuttals or explanations by the practitioner or AHP.

5) A third infraction, corroborated and verified by factual and impartial documentation within a 4-year time frame from the initial incident necessitates a mandated appearance before the MEC to explain why the inappropriate behavior has continued despite documented efforts to curtail it. Routine corrective action as described in the Medical Staff Bylaws may be instituted by the MEC such as letters of warning or censure, mandated counseling, or educational requirements.

6) Continued inappropriate behavior corroborated and verified by factual and impartial documentation within a 2-year time frame from the routine corrective action of the MEC may lead to a formal investigation and consideration of corrective action up to and including revocation of medical staff membership pursuant to the medical staff bylaws

7) Recommendation for referral to the Practitioner's Assistance Committee may be made at any time as deemed appropriate.

8) At the time of reappointment, assessment of inappropriate behavior included in the practitioner's or AHP's peer review file will be evaluated by the Department/Section Chair to determine if a follow-up meeting is necessary.. If there are no reported incidents and no related action has been taken or is pending during that reappointment cycle, the Department/Section may consider expunging previous complaints from the peer review file.

9) Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstances. Retaliation or attempted retaliation by members against complainants will give rise to corrective action pursuant to the medical staff bylaws.

10) Individuals who submit a complaint or complaints which are determined to be false shall be subject to corrective action under the medical staff bylaws or hospital employment policies whichever applies to the individual.

Am J Nurs. 2005 Jan;105(1):54-64; quiz 64-5. Disruptive behavior and clinical outcomes: perceptions of nurses and physicians. Rosenstein AH[1], O'Daniel M.

Am J Nurs. 2002 Jun;102(6):26-34. Original research: nurse-physician relationships: impact on nurse satisfaction and retention. Rosenstein AH[1].

Sample #2 from John Muir Medical Center Medical Staff Policies

Code of Conduct Policy and Procedure: General Expectations, Examples of Inappropriate Conduct

POLICY AND PURPOSE

The Medical Staff is committed to supporting a culture that values integrity, honesty, and fair dealing with each other and to promoting understanding and sensitivity to diversity, responsible attitude towards and a caring environment for patients, Medical Staff Members and employees. The Medical Staff also endeavors to create and promote an environment that is professional, collegial, and exemplifies excellent patient care and research. Towards these goals, the Medical Staff strives to maintain a workplace that is free from harassment or discrimination in compliance with state and federal laws. This includes behavior that could be perceived as inappropriate, harassing or that does not endeavor to meet the highest standard of professionalism.

The purpose of this “Code of Conduct” Policy is to clarify the expectations of all physicians and Allied Health Professionals (AHP’s) granted Medical Staff membership and/or Privileges at John Muir Health (JMH) during any and all interactions with persons at the Medical Center, whether such persons are colleagues, other healthcare professionals, and/or other individuals, in order to ensure that neither the quality of patient care is adversely affected nor the smooth functioning of the patient care team is interrupted. This Policy and Procedure is intended to address conduct which does not meet the professional standards expected of a Medical Center Medical Staff Member. In dealing with incidents of inappropriate conduct, the protection of patients, employees, Medical Staff Members, and other persons at the Medical Center and the orderly operation of the Medical Center are primary concerns. In addition, the Wellbeing of a Medical Staff Member whose conduct is in question is also of concern.

GENERAL EXPECTATIONS

Upon receiving Medical Staff membership and/or Privileges at JMH (JMWC or JMCC), such Privileged Medical and Allied Staff Members enter into a common goal with all members of the organization to endeavor to maintain the highest quality of patient care and professional conduct.

Interactions with all JMH patients, visitors, employees, Medical Staff Members or any other individual shall be conducted with courtesy, respect, and dignity. Medical staff members are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the healthcare team.

All Privileged Medical Staff Members are expected to refrain from conduct that may be reasonably considered offensive to others or disruptive to the workplace or patient care. Offensive conduct may be written, oral or behavioral and would include, but not be limited to, the use of profanity, sexual comments or images, racial or ethnic slurs, gender-specific comments, or any comments that would offend someone on the basis of his or her age, race, color, marital status, sex, sexual orientation, religion, national origin, or ancestry, physical or mental handicap.

The delivery of clinical care shall promote compliance with patient safety and abide by the National Patient Safety Goals as specified in system and medical center policies and procedures. Documentation of care shall be legible and timely and included proper informed consent prior to procedures or treatment. Physicians are expected to refrain from including impertinent and/or inappropriate comments and illustrations. Communication of clinical care shall be compliant with HIPAA and California Privacy Laws with regard to the access, use and communication of patient information, electronically or otherwise.

The delivery of care shall promote a caring environment for patients. Physicians shall be expected to be available, responsive and approachable by maintaining current contact information with the Medical Staff Office, including after-hours phone or pager, and an e-mail address that is checked regularly, and arrange for appropriate coverage when not available

All staff are expected to be easily identifiable by others in the hospital by wearing Medical Center-issued identification badge and attire that reflects his/her professional role. In their interactions, privileged members are also expected to demonstrate support for the hospital-wide Service Excellence Program and/or “Culture of Caring” goals.

Physicians are expected to maintain a collegial environment that promotes quality by participating in peer review activities by responding to concerns made by peers in a timely fashion, by agreeing to serve in peer review activities when requested, and maintaining absolute confidentiality in peer review of others. In addition they are expected to take advantage of opportunities to improve quality of care in their individual practices in the hospital by participating in continuing education activities.

Disagreements among individuals are to be handled with courtesy, respect, and dignity for one another. Privileged Medical Staff Members must refrain from arguments with any other individual in public or work areas that may be overheard by patients, visitors, or employees or other non-involved individuals. Medical Staff Members must also refrain from conduct which may reasonably be considered threatening, whether the threat is expressed or implied.

As healthcare team leaders, physicians are also expected to develop and institute a plan to manage stress and promote personal health and Wellbeing, and are encouraged to consult the Well Being of Physicians Committee for assistance or referral.

EXAMPLES OF INAPPROPRIATE CONDUCT

A. Examples of "inappropriate conduct" include, but are not limited to:

1. Threatening or abusive language directed at nurses, hospital personnel, or other Medical Staff Members (e.g., belittling, berating, and/or threatening another individual);

2. Degrading or demeaning comments regarding patients, families, nurses, Medical Staff Members, hospital personnel or the Medical Center;

3. Profanity or similarly offensive language while in the hospital and/or while speaking with nurses or other hospital personnel; and/or

4. Physical behavior with another individual that is threatening or intimidating including visual intimidation.

5. Engaging in romantic and/or sexual relationships with current patients.

B. The Medical Staff does not tolerate, and may take immediate action pursuant to Medical Staff Bylaws in instances where failure to do so may result in imminent danger to the health of any individual. In these instances the report of conduct will be immediately referred to one of the Medical Staff Officers and Department Chair:

Deliberate physical intimidation or challenge, including bumping, pushing, grabbing or striking another person in the hospital;

Criminal acts

Practicing while impaired by alcohol, drugs or illness

Retaliation or retribution against those who have filed reports regarding physician performance or participated in any medical staff process regarding a physician

Carrying a gun or other weapon in the hospital

PROCEDURE

A. Privileged individuals will be required to renew their agreement to abide by this Code of Conduct prior to initial appointment and any subsequent reappointment.

B. Conduct that may pose an imminent danger to patient safety shall be referred immediately to one of the Medical Staff Officers and Department Chair for further action.

C. Questions or concerns regarding a Medical Staff Member's health or Wellbeing shall be referred to the Wellbeing of Physicians Committee for consideration and action as necessary, pursuant to Medical Staff Rules and Regulations and policy(ies).

D. Conduct that may constitute sexual harassment shall be referred to the appropriate Campus Chief of Staff for further action.

E. The Department Chair, upon receipt of a report of inappropriate conduct, shall determine whether immediate action is required in accordance with Medical Staff Policy, "Processing of Complaints Involving Professional Behavior of Medical Staff Members."

If the Department Chair determines that an incident of inappropriate conduct has not occurred, no documentation of the incident will be recorded in any of the Medical Staff member's files maintained confidentially in the Medical Staff Office for tracking, trending, and oversight purposes. However, if it is determined that an incident is considered a validated complaint, the Department Chair shall meet with the Privileged Medical Staff Member as soon as possible. At the meeting, the Department Chair shall communicate to the Medical Staff Member:

his/her observed inappropriate behavior;

his/her expected behavior going forward;

the consequences of any repeat conduct;

any necessary monitoring or follow-up; and

that any perceived retaliation may result in immediate disciplinary action.

The Department Chair will provide the privileged Medical Staff Member with a written summary of the meeting and shall forward a copy of the written summary to the Chief of Staff and Chair of Physician Wellbeing Committee.

The Department Chair will assure appropriate feedback to the reporting individual. Notwithstanding the foregoing, no information deemed privileged shall be released to any individual outside the peer review process.

CONSEQUENCES OF FAILURE TO COMPLY WITH POLICY

Privileged Medical Staff Members who do not act in accordance with this Policy and all other Medical Center and Medical Staff policies, procedures, rules, regulations, and standards of conduct may be subject to peer review and/or disciplinary action.

ACKNOWLEDGEMENT

As a member of or applicant to the John Muir Medical / Allied Health Staff, Walnut Creek and/or Concord Campus, or a physician or allied health practitioner granted privileges or practice approval, I understand these expectations and agree to abide by the Code of Conduct:

Signature: _____ Date: _____

Effective Date: 9/22/2010. Approved: Well Being of Physicians/Medical Advisory Committees: 4/14/10 Medical Executive Committee Concord 9/7/10 Medical Executive Committee Walnut Creek 9/13/10 Board of Directors: 9/22/2010

References: Joint Commission SEA 40, California Medical Association Model Bylaws 2009, American Medical Association Code of Ethics, Cedars Sinai COC

APPENDIX D: DIAGNOSES REALTED TO BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

This appendix lists diagnoses that are associated with behaviors that undermine a culture of safety as they are defined in the *Diagnostic and Statistical Manuals* (DSM) of the American Psychiatric Association, both editions DSM-IV and DSM-5.

Personality Disorders (listed under Axis II in DSM-IV)

Examples to consider include the following:

- Paranoid Personality Disorder: a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent
- Narcissistic Personality Disorder: a pattern of grandiosity, need for admiration, and lack of empathy
- Passive-aggressive Personality Disorder: a pattern of negativistic attitudes and passive resistance to requirements for adequate performance in social and occupational situations (pp 733-734, DSM-IV)
- Obsessive-compulsive Personality Disorder: A pattern of preoccupation with orderliness, perfectionism, and control (Obsessive-compulsive Personality Disorder should not be confused with Obsessive-compulsive Disorder)

Other diagnoses

Other DSM-5 diagnoses that may be associated with behaviors that undermine a culture of safety include the following:

- Bipolar and related disorders
- Depressive disorders
- Anxiety disorders
- Adjustment disorders
- Substance-related and addictive disorders
- Intermittent Explosive Disorder

References

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (2013)

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (1994)

Mello LJ, Psychiatric Conditions Affecting Physicians With Disruptive Behavior. Psychiatric Times November 20, 2014

http://www.psychiatrictimes.com/mood-disorders/psychiatric-conditions-affecting-physicians-disruptive-behavior?GUID=495D591E-2FFB-49D8-8E15-4A95F00A5FF1&rememberme=1&ts=20112014

APPENDIX E: SAMPLE AGREEMENTS FOR MONITORING OF BEHAVIORAL ISSUES

Sample #1 from Stanford School of Medicine (2014)

***MODEL TEMPLATE AGREEMENT FOR BEHAVIORAL* ISSUES**

Practitioner Name: _____

Address and Phone: _____

This Agreement ("Agreement") is entered into as of [date] by and between the Wellbeing Committee ("Committee") on behalf of the Medical Staff ("Medical Staff') of [name of hospital] and [practitioner's name] ("Dr. __"), as a condition of [specify] at the Hospital.

Dr. _____ acknowledges that he/she has engaged in certain conduct that is deemed unacceptable in that it may interfere with his/her effective clinical performance or interfere with the ability of others to achieve quality patient care.

The Medical Staff and Dr. _____ wish to establish a method of assessing and monitoring Dr. _____ 's ability to modify his/her behavior in order that he/she may safely assume and maintain patient care responsibilities at the Hospital.

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound hereby, the parties hereto agree as follows:

1. Acknowledgment. Dr. _____ hereby acknowledges that the alleged unacceptable conduct occurred.

2. Assurance. Dr. _____ hereby assures the Committee that the alleged conduct has not recurred, and will not occur again, and that he/she has availed himself/herself of professional treatment with regard to the alleged conduct. Dr. _____ further assures the Committee that he/she is able to safely assume and maintain his/her patient care responsibilities at the Hospital.

3. Assessment. Dr. _____ shall promptly arrange for an assessment of his/her health by _____, M.D., or such other physician(s) as may later be designated by the Committee ("provider(s)"). The purpose of the assessment is to provide a medical opinion regarding Dr. _____'s fitness for duty as well as to determine Dr. _____'s ability to adhere to accepted standards of professional conduct and to make recommendations to the Committee for an appropriate monitoring plan.

4. Monitoring Plan. Dr. _____ shall participate in and adhere to a monitoring plan prescribed by the Committee after consultation with the provider(s). The elements of the monitoring plan may include, but need not be limited to, those set forth below.

a. Dr. shall promptly arrange for participation in treatment with the provider(s) at such frequency and for such period of time as may be deemed appropriate by the Committee and his/her care provider.

b. Dr. _____shall promptly arrange for periodic feedback by the provider(s) to the Committee at such frequency and for such period of time as may be deemed appropriate by the Committee, to include, but not be limited to, verification of Dr. _____'s participation in treatment, and whether he/she is progressing toward treatment goals.

c. Dr. _____ shall participate in face-to-face conferences with a Work Site Monitor appointed by the Committee. Such conferences shall be at such frequency and for such period of time as deemed appropriate by the Committee, but at least quarterly. The purpose of the conferences is to provide for a regular reassessment of Dr. _____ 's ability to adhere to acceptable standards of professional conduct, and deliver appropriate patient care, and the sufficiency of the monitoring plan.

d. There may be concurrent and regular record review, at the discretion of the Committee, of Dr. _____'s cases in a manner and as frequently as deemed appropriate by the Committee. A written report of any such reviews shall be given to the Work Site Monitor.

e. The monitoring plan may be modified only when, and shall continue in effect for as long as, deemed appropriate by the Committee.

f. Dr. _____ shall bear all expenses in connection with the monitoring plan, including, but not limited to, the assessment(s) described in Section 3 above, any and all additional assessment(s), the periodic feedback from the provider(s) and any required treatment.

5. Work Site Monitor. ____, M.D., shall serve as the Work Site Monitor for Dr. ____.

6. Authorization. To facilitate the foregoing assessment(s) and establishment of the monitoring plan, Dr. _____ hereby authorizes the Committee and the provider(s) to provide to each other information in the possession of any of them, including copies of reports or correspondence relating to any concerns or observations about Dr. _____’s professional conduct or performance at the Hospital or elsewhere, and all medical records pertaining to Dr. _____, and/or summaries with respect thereto ("Confidential Information").

7. Confidentiality. The Committee shall keep any and all Confidential Information it receives about Dr. _____ pursuant to this Agreement in confidential Committee files unless otherwise authorized under Section 6 above or required to disclose it (1) pursuant to a court order or a lawful subpoena; (2) TO prosecute corrective actions, if any, in accordance with the Medical Staff Bylaws, (3) as and to the extent necessary to enforce compliance with this Agreement, or (4) as otherwise required by law.

8. Observance of Laws. Dr. _____ shall observe all federal, state, local, Hospital and Medical Staff statutes, regulations, standards, bylaws, rules and regulations and policies and procedures governing his/her professional practice in California and his/her Medical Staff membership and clinical privileges at the Hospital.

9. Failure to Comply. Dr. _____ shall be immediately and automatically referred to the Hospital's Medical Board or other appropriate entities or individuals for appropriate corrective action in accordance with the Hospital's Medical Staff Bylaws, including, but not limited to, summary suspension and/or termination of Medical Staff membership and all clinical privileges if he/she fails to comply with this Agreement. Nothing in this Section 9 shall limit the Committee's authority to make referrals for, or the authority of the Hospital's Medical Staff, Medical Board, Medical Staff Officers, Administrator, and/or Board of Directors to take appropriate corrective action in accordance with the Medical Staff Bylaws.

10. Release. Dr. _____ hereby releases and forever discharges the Hospital, the Medical Staff, the Committee, and the entities and individuals listed in Section 6 above, their officers, directors, employees, members, agents, representatives, consultants and attorneys, from and against any claims, demands, obligations, costs incurred, expenditures, damages or causes of action of any nature whatsoever, for their acts and omissions performed in good faith and in compliance with this Agreement.

11. Term. This Agreement shall remain in full force and effect for a period of one (1) year from the date above written (unless sooner terminated in writing by the parties), at which time the Committee shall reassess the need for continuing it.

12. Amendments. Any amendments of this Agreement shall not be binding on the parties unless made in writing and signed by them.

13. Periodic Reevaluation. This Agreement shall be reevaluated by the Committee at such intervals as the Committee deems appropriate to keep it tailored to current circumstances.

14. Definition. The term "promptly" as used in this Agreement shall mean within five (5) business days of the event or occurrence.

15. Notice. Written notice or reports due under this Agreement shall be sent as follows: If to the Committee, to: _____ , M.D., Chair Wellbeing Committee Address: Fax: ____, Phone: ___, A facsimile notice or report shall suffice.

16. Integration. This Agreement supersedes any and all other agreements, whether oral or in writing, between the parties with respect to the subject matter of this Agreement.

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound hereby, have signed their names on the day and year written below.

Dated: _____ By: _____

Dated: _____ By: _____ , M.D.,
Chair Wellbeing Committee

Sample #2 from Massachusetts PHP

Physician Behavioral Health Monitoring Agreement

PHYSICIAN HEALTH SERVICES, INC.
A MASSACHUSETTS MEDICAL SOCIETY CORPORATION

Physician's Name_____ PHS ID Number_____
PLEASE PRINT OR TYPE CLEARLY

Last Name: _____ First Name: _____ Suffix: _____, Degree: _____
Gender: _____
Title: _____
Hospital: _____
Primary Specialty: _____ Second Specialty: _____

Date of Birth: _____ / _____ / _____

Spouse/Significant Other (optional): Last Name: _____ First Name: _____

(1) Home Address
Address: _____
Phone: _____ Cell Phone: _____
Email Address: _____

(2) Work Address
Address: _____
Phone: _____
Email Address: _____

(3) Other Address
Address: _____
Phone: _____

(4) Preferred Mail Address
HOME WORK OTHER
Preferred Place of Contact
Home phone Work phone Cell Phone Other

(5) PHS Associate Director
Last Name: _____ First Name: _____
Phone: _____

(6) For each of these individuals

Chief of Service 1
Chief of Service 2
Therapist -- If therapist is not a medical doctor, please designate a psychiatrist to be available as needed, or list a psychopharmacologist.
Psychiatrist
Monitor
Alternate Monitor
Primary Care Physician
Attorney (If applicable)

Provide this information:

Last Name: _____ First Name: _____ Suffix: _____, Degree: _____
Title: _____
Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone:_____ Ext: _____

(7) Other Information

Inpatient Treatment:
Not Applicable
Applicable Date Entering: _____
Facility: _____

Therapy Frequency:

_____

Support Group Meetings (name of groups and locations):

_____

_____

Support Group Frequency:

_____

iii

Physician Health Services
A Massachusetts Medical Society Corporation

PHS ID # : _____

PHYSICIAN HEALTH SERVICES, INC.
A MASSACHUSETTS MEDICAL SOCIETY CORPORATION

PHYSICIAN BEHAVIORAL HEALTH MONITORING CONTRACT (2014)

I, , agree to the terms of this contract with Physician Health Services (PHS). I understand that PHS will provide documentation of my behavioral health, which, upon my written authorization or request, will be made available to third parties. I also understand that failure to abide by the terms of this contract may result in information regarding my lack of compliance being reported to the Board of Registration in Medicine, my chief(s) of service, my monitor(s), my therapist, my primary care physician and any others as authorized by the releases that I may sign. With this understanding, I hereby agree to the following terms and conditions:

1. PHS Associate Director

PHS will designate an associate director to assist me with this contract. I agree to maintain contact with this associate director on a regular basis and to have a face-to-face meeting with him or her at least once a month. I will increase the frequency of meetings at the request of the associate director or the director of PHS.

2. Notification to Prescribing Practitioners

I understand that I must inform PHS of all prescriptions and over the counter medications that I am taking. In Massachusetts, all prescription medications are considered “controlled.” If I require a controlled substance, it must be administered or prescribed by another practitioner who is aware of the nature of this contract and it will be for a legitimate medical purpose. I shall immediately inform my associate director of my use of all medications. Upon request, copies of prescriptions must be provided to PHS.

3. Therapy

I will receive treatment for my behavioral health from a licensed therapist who is approved by PHS. I will see this therapist _____ time(s) a week for the first six months of this contract, and then on a schedule as determined by my therapist, but no less than monthly unless approved by the therapist and the director of PHS. The selection of my therapist and schedule of appointments issubject to the approval of the director of PHS.

I have selected _____, MD, as the psychiatrist who will be my therapist.

Under certain limited circumstances the director of PHS may approve a non-MD therapist. In these circumstances the therapist will associate with a psychiatrist who will be available as needed.

My therapist is _____

The psychiatrist is _____

I have asked and my therapist/psychiatrist has agreed to provide quarterly reports to PHS documenting compliance with prescribed and over-the-counter medications, adherence to treatment recommendations and the frequency of meetings. Otherwise the specific content of my therapy remains confidential.

I understand that my therapist/psychiatrist is also obligated by this contract to report to the director of PHS when I may pose a risk to myself or others.

4. Primary Care Physician and Physical Examination

I have selected _____, M.D. as my primary care physician. I have informed this physician of the purpose of this contract and my medical history, and he or she has agreed to assist with my care. I agree to comply with primary care physician visits at a frequency determined by my primary care physician.

I will have/have had a physical examination within 60 days. I will provide PHS with documentation of a physical examination within 60 days from the effective date of this contract.

I agree to submit to any other examination or testing requested by the director of PHS, my primary care physician and/or therapist. I realize this contract may be amended following the results of those exams.

5. Monitor and Chief of Service

I have selected a physician who agrees to be a monitor and who is aware of the purpose of this contract. I will see this monitor regularly (at least weekly) so that he or she can attest to my behavioral health. If I am working, I will select a monitor at each of my work sites. I shall have contact with my monitor at my workplace, unless otherwise approved by the director of PHS. If for any reason my monitor becomes unavailable to me on a regular basis, I will notify my PHS associate director and make alternative arrangements that meet with the approval of the director of PHS.

I agree designate a chief of service at each of my work sites and make this individual aware of this contract and my behavioral health. In the absence of a chief of service, I will make alternative arrangements that meet the approval of the director of PHS. I authorize my chief of service to exchange information with PHS relevant to my health, monitoring or any risk of impairment or my ability to practice.

6. My practice will be monitored as follows:

Monitoring to consist of maintaining reasonable care and treatment for my behavioral health, which currently includes:

a. Diagnosis(es)

b. Adherence to my therapists' recommendations with prescribed and over-the-counter medications, treatment recommendations and the frequency of meetings;

c. Maintaining reasonable behavioral patterns and standards.

Note examples of behavioral concerns outlined in enclosure titled "Signs of Concerns for Physicians Monitored by Physician Health Services;"

d. _____

_____

e. _____

_____

7. Inpatient and Other Treatment

I agree to enter inpatient treatment or participate in evaluation, if recommended by my therapist or the director of PHS, on or by _ [date] __ and will remain until discharged with the approval of my therapist, treatment provider or independent evaluator. I will provide notification to PHS of the date I begin treatment and of the date I complete or leave treatment, and will immediately resume PHS monitoring.

Facility: _____

Therapist/Treatment Provider:_____

I further agree that I will participate in evaluation, or any treatment modality at any time over the course of this contract if requested by my therapist or recommended by the director of PHS.

PHS is authorized to notify my chief of service, my monitor(s), and my therapist of my treatment status and my involvement with PHS.

8. Peer Support Groups

I will attend a peer support group or other support group approved by the director of PHS once a month throughout the term of this contract. I will provide documentation of the same to PHS including the date, location, and brief topic of the meeting.

9. Duty To Notify

If my ability to practice medicine becomes impaired, I will immediately suspend any clinical responsibilities and inform my chief of service, monitor(s), therapist and PHS of the circumstances regarding the impairment**.**

I agree not to practice medicine until my therapist, treatment provider or approved evaluator determines that it is advisable. I will authorize PHS to notify the Board of Registration in Medicine and my chief of service if I return to practice prior to the approval of my therapist, or approved evaluator who will determine my ability to practice.

I agree to comply with any directives, contracts or agreements from or with the Board of Registration in Medicine.

10. Monitors/Quarterly Reports

I have selected the following individuals who have agreed to assist in monitoring my behavioral health. I agree that the monitors will provide information and written reports to PHS. I understand that all monitors are subject to the approval of the director of PHS.

Hospital Chief of Service (I) (for trainees, the training director):

Hospital Chief of Service (2):

Monitor:

Alternate Monitor:

Therapist:

Psychiatrist:

I authorize the individuals named above to provide written reports to PHS every three months, and to provide any information to PHS at any time that there is information relevant to my behavioral health, impairment, or risk for impairment.

11. Documents

I will furnish PHS with copies of all correspondence and legal documents with the Board of Registration in Medicine and the licensing boards of any other states in which I have licensure. I will provide PHS with a copy of any licensing applications and renewal forms that I submit to the Board of Registration in Medicine during the course of this contract.

I will disclose and furnish PHS with verbal or written copies of any and all complaints about my professional performance, including malpractice complaints, Board of Registration in Medicine complaints, and adverse reports from peer review agencies, credentialing agencies or hospital or other health care facility or organization departments.

12. Letters of Compliance

PHS shall provide documentation of my participation in the monitoring program to third parties upon my written request and signing of the appropriate releases.

13. Breach of Contract – Reports

I understand that failure to abide by any of the conditions set forth in this contract shall constitute a breach of contract and may be reported to the Board of Registration in Medicine, my chief of service, monitors, therapist, primary care physician and other third parties named in signed releases as well as other agencies, entities, or individuals as PHS deems necessary to protect the public. I also agree that the Board of Registration in Medicine will be notified and relevant information will be disclosed as to any of the following conditions:

If I am known to the director of PHS or my therapist or psychiatrist to have an exacerbation of my condition such that my judgment or reason is impaired.

If PHS has a reasonable basis to believe that I, for any reason, cannot render professional services without risk to the public.

If I revoke consent to disclose information to the Board of Registration in Medicine during the course of this contract.

If this contract is terminated for any reason other than successful completion as determined by the director of PHS.

Information regarding my compliance, or lack of compliance with this contract may be released pursuant to the terms of any probationary agreement, letter of agreement or other monitoring agreement with the Board of Registration in Medicine.

I agree to waive any confidentiality protections that may be available to me under state or federal laws so that the above-referenced reports may be made to the Board of Registration in Medicine, my chief of service, my therapist, my monitors and others named in releases that I may sign.

If I fail to meet my obligations under this contract, PHS may notify anyone to whom representations as to my compliance with this contract have been made, alerting them to such failure.

14. Substance Use

I agree not to use alcohol in excess, abuse any controlled substances or over-the-counter preparations, or use illegal drugs. If I am determined to be abusing addictive substances, I will enter into a PHS substance use monitoring contract with PHS. I understand that failure to sign this contract may be considered lack of compliance with this contract and may be reportable to the Board of Registration in Medicine.

15. Communication Among PHS, Monitors, and Physicians

I agree to waive any confidentiality protections that may be available to me under state or federal laws so that PHS, and all the individuals named within this contract may communicate openly about my compliance with the terms of this contract. However, I understand that information regarding my treatment is confidential except as provided by law and stated within this contract.

16. Interstate Agreement

I agree that PHS may contact the physician health program of any state where I am presently licensed or where I may relocate during the term of this contract. I agree to execute a release of information to facilitate this communication. I understand that failure to do so will be considered lack of compliance with this contract.

17. Notification of Updated Information

I agree to notify PHS of any changes in my physical or behavioral health including hospitalizations. I further agree to notify PHS of changes of address or employment.

18. Effective Date

This contract shall take effect on _____ and shall terminate in two years. This contract be extended so that I may comply with a Letter of Agreement, Probation Agreement, or condition of licensure that may be required by the Board of Registration in Medicine. This contract will not, however, take effect until the appropriate releases have been signed and all monitoring arrangements have been made as determined by the director of PHS. The length of this contract may be extended based on the length of time of any extended absences in monitoring.

AGREED TO: _____

Physician Signature Date

ACCEPTED BY:

_____

Associate Director

_____

Director, Physician Health Services

POSTSCRIPT TO
PHYSICIAN BEHAVIORAL HEALTH MONITORING CONTRACT (2014)
FROM PHYSICIAN HEALTH SERVICES
A MASSACHUSETTS MEDICAL SOCIETY CORPORATION

SIGNS OF CONCERN FOR PHYSICIANS MONITORED BY PHYSICIAN HEALTH SERVICES FOR BEHAVIORAL HEALTH

A. Personal

Deteriorating personal hygiene

Multiple physical complaints

Personality and/or behavioral changes

Rapid or pressured speech

Mood swings

Bizarre behavior

Inappropriate anger and/or abusive language

B. Professional

Disorganized schedule

Erratic behavior – arguments or altercations with patients and/or staff

Inaccessibility to patients and/or staff, patient complaints, calls not being returned

Unable to keep up with workload

Frequent lateness, absence, or illness

Impaired or decreased work performance

Poor and/or untimely record keeping -- failure to respond to requests to catch up

Inappropriate orders

Disregard of practice standards, institutional rules or laws

Inappropriate response to patients needs, supervisor, or staff requests

Unprofessional demeanor or conduct

Uncooperative, defiant approach to problems

Disruptive behaviors

APPENDIX F: LEGAL ISSUES

This appendix is included in addition to the section of the paper titled “Legal Considerations on Which Policies Are Based .” Some of the material in this appendix repeats material in the earlier section for the purpose of providing more detail and expanding the comments.

CALIFORNIA LAW

There are several laws in California which protect persons from discrimination and retaliation. What follows is a brief description of these provisions.

The Fair Employment and Housing Act (FEHA) prohibits harassment and discrimination in employment because of race, color, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, national origin, ancestry, mental and physical disability, medical condition, age, pregnancy, denial of medical and family care leave, or pregnancy disability leave. It requires employers to take all reasonable steps to prevent harassment from occurring. (Gov. Code §§ 12940,12945 and 12945.2)

Civil Code §1708.7 is California’s anti-stalking law, which prohibits a pattern of conduct the intent of which is to follow, alarm, or harass and which creates a reasonable fear for someone’s safety.

The Workplace Violence Safety Act allows employers to seek a temporary restraining order to protect employees, co-workers and workplace property from threats of acts of violence. (Code Civ. Proc. §527.8)

California Penal Code §71 prohibits any person from threatening or inflicting unlawful injury upon any public officer or employee, which would cause the public officer, or employee to refrain from doing any act in the performance of his/her duties.

Labor Code §6400 requires every employer to furnish a safe and healthful place of employment. It is unlawful for an employer to harass an employee, or to allow harassment of employees. (See Gov. Code §§ 12940 – 12951.) Hospitals, as employers of nursing and support staff, have an obligation to ensure that employees are provided with a safe workplace, including an environment free from harassment. In addition, the law places an affirmative duty on an entity to take “immediate and appropriate corrective action” or the conduct is defined as “unlawful.” (See Gov. Code §12940 (j)(1).) In a practical sense, this means that a hospital must promptly investigate alleged discrimination, harassment and/or retaliation and take such remedial actions as are available to the hospital. This may include taking affirmative action to address conduct by a disruptive physician to protect employees. Section 12940(j)(4)(A) defines an “employer” to include “any person . . . regularly receiving the services of one or more persons providing services pursuant to a contract, or any person acting as an agent of an employer, directly or indirectly. . .” Recently a court has held a

physician may be an agent of a hospital. (See *Whitlow v. Rideout* (2015) 237 Cal.App. 4th 631.) It is arguable that even a medical staff, independent of a hospital, may owe a duty under this statute.

In 2014, the California Legislature also passed an anti-bullying education law which requires employers with 50 or more employees to include education regarding "prevention of abusive conduct" in previously–required sexual harassment training and education. "Abusive conduct" is defined as " . . . conduct of an employer or employee in the workplace, with malice, that a reasonable person would find hostile, offensive, and unrelated to an employer's legitimate business interests. [It] may include repeated infliction of verbal abuse, such as the use of derogatory remarks, insults, and epithets, verbal or physical conduct that a reasonable person would find threatening, intimidating, or humiliating, or the gratuitous sabotage or undermining of a person's work performance. " The law adds that a "single act shall not constitute abusive conduct, unless especially severe or egregious." Thus, it can be argued an employer such as an acute care hospital owes an obligation to its employees to act to prevent hostile, offensive behaviors from disruptive physicians. Again, the Legislature broadly defines who is an "employer" for purposes of owing obligations under this statute, including any person regularly employing 50 or more persons or regularly receiving the services of 50 or more persons providing services pursuant to a contract, or any person acting as an agent of an employer. . . " (Gov. Code §12950.1)

For public health care providers, another law specifies that workplace violence, discourteous treatment, negligence and/or recklessness constitute causes for employment discipline. (Gov. Code §19572.)

In California, the process of adopting standards to govern the behavior of Medical Staff members is the responsibility of the Medical Staff, which is independently responsible "for policing its member physicians" (Health & Safety Code §1250(a); Cal. Code Regs., tit 22 §70701(A)(1)(F); Bus. & Prof. Code §2282.5. California law also charges medical staffs with the responsibility for credentialing and supervision of many of the other licensed healthcare professionals who perform care and treatment of patients. (Cal. Code Regs., tit. 22, § 70706 et seq.)

FEDERAL LAW

In addition to state law, there are several federal laws that also provide protection from discrimination and retaliation. Below, are brief descriptions of those provisions.

Title VII of the Civil Rights Act of 1964 (Title VII) makes it illegal to discriminate against someone on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or a medical condition related to pregnancy or childbirth. The law also makes it illegal to retaliate against a person because the person complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit. The law also requires that employers reasonably accommodate applicants' and employees'

sincerely held religious practices, unless doing so would impose an undue hardship on the operation of the employer's business.

The Equal Pay Act of 1963 (Pub. L. 88-38) (EPA) makes it illegal to pay different wages to men and women if they perform equal work in the same workplace. The law also makes it illegal to retaliate against a person because the person complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit.

The Genetic Information Nondiscrimination Act of 2008 (Pub. L. 110-233. 122 Stat/ 881. Enacted May 21, 2008) (GINA) makes it illegal to discriminate against employees or applicants because of genetic information. Genetic information includes information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about any disease, disorder or condition of an individual's family members (i.e. an individual's family medical history). The law also makes it illegal to retaliate against a person because the person complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit.

The Rehabilitation Act of 1973 (29 U.S.C. §701 et. seq.) and the Americans with Disabilities Act (ADA) (42 U.S.C. §12101) is applicable to employers with 15 or more employees. The purposes of these laws are to provide a clear national mandate to end discrimination against individuals with physical and/or mental disabilities. The ADA is a comprehensive anti-discrimination statute that prohibits discrimination against individuals with disabilities in private, state, and local government employment, and in the provision of public accommodations, public transportation, state and local government services, and telecommunications.

The ADA is relevant to the issue of disruptive behavior. Persons must be qualified to perform the basic functions of their job, but they may seek protection under the law because of a debilitating physical or mental condition that can be reasonably accommodated. A disabled individual may be denied employment or discharged only where: (1) that individual poses a direct threat to the health and safety of others; and (2) the direct threat cannot be reduced or eliminated by a reasonable accommodation without undue hardship.

Persons may also seek protection under the ADA if they develop a debilitating condition which mandates reasonable accommodation(s) to enable them to perform on the job as a result of the disruptive behavior and their employer fails to comply with the provisions of the Family and Medical Leave Act (FMLA) of 1993 (29 U. S. C. §2601, et. seq.). The FMLA guarantees an eligible worker the right to take up to 12 weeks of unpaid, job protected leave in a year to care for one's own serious health condition or to attend to family members' serious health conditions.

The Occupational Safety and Health Administration (OSHA) establishes standards for maintaining safe work environments. Employers must comply with the general duty clause

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which states that each employer must furnish a place of employment that is “free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees. (Section 5(a)(1) of the Occupational Safety and Health Act of 1970.) OSHA covers most private sector employers and workers and has both a federal and state component

The Centers for Medicare & Medicaid Services (CMS) Conditions of Participation require a medical staff be accountable to the governing body for the quality of all care provided to patients. (42 C.F. R. § 482.12(a).) In addition, the Conditions of Participation prohibits recipients of federal funding from engaging in acts of discrimination against any person, which would include staff and/or employees. (45 C.F.R. § 84.1, et seq.)

A Sampling of Federal Cases Re Disruptive Behavior

Gordon v. Lewistown Hosp.,(2005) 423 F.3d 184, 205 [although physician's professional competence was never in dispute, unprofessional conduct such as calling another doctor's patient and making derogatory comments was within the purview of a "professional review action" under the HCQIA];

Leal v. Sec'y (2010) 620 F.3d 1280, 1285 [Disruptive and abusive behavior by a physician, even if not resulting in actual or immediate harm to a patient, poses a serious threat to patient health or welfare.];

A federal court in California, dealing with a claim of denial of federal due process related to disciplinary action taken at a district hospital held:

> Absent some form of cross-cultural misunderstanding, it can generally be said that a person is intolerably and disruptively rude and abrasive when the persons on the receiving end of his communications collectively determine that he is. When the individuals who have been on the receiving end of the individual's communications determine that the individual's rudeness and/or disruptive behavior has reached a level that potentially compromises care of any patient, that conclusion is generally not susceptible to argument to the contrary.

(Jablonsky v. Sierra Kings Healthcare Dist. (2011) 798 F.Supp.2d 1148, 1154.)

THE JOINT COMMISSION – The Joint Commission since 2007

In addition to statutory requirements, accreditation bodies require facilities address disruptive behaviors. The Joint Commission (TJC) obligates hospitals to establish a code of conduct for all persons working in the hospital. (LD.03.01.01, E)

On July 9, 2008, The Joint Commission issued a “Sentinel Event Alert” discussing new Leadership Standard LD.03.01.01 and its related Elements of Performance, EP4 and EP5, which became effective January 1, 2009. The Standard requires hospital leaders adopt a

code of conduct defining disruptive behavior and establishing a process for managing such behavior.

The Standard does not, itself, define, disruptive behavior, but the accompanying Sentinel Event Alert states that such behaviors include ". . . overt acts such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities . . . . Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients. The Elements of Performance related to the new Leadership Standard mandate that:

> EP4: Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety
>
> EP5: Leaders create and implement a process for managing behaviors that undermine a culture of safety

Effective July 1, 2012 JACHO revised these Elements of Performance to delete reference to the phrase "disruptive and inappropriate behaviors." JACHO explained that the term "disruptive behavior" can be considered ambiguous and noted that physicians who express strong advocacy for improvements in patient care can be inappropriately characterized as disruptive. Accordingly, JACHO adopted the phrase "behaviors that undermine a culture of safety" in place of "disruptive behavior."

JACHO's Sentinel Alert offers a number of "suggested actions to address disruptive behavior. Each hospital and Medical Staff should consider the usefulness of the following:

- •Educate all team members, both physicians and non-physician staff, on appropriate professional behavior as defined by the organization's Code of Conduct;
- •Hold all team members accountable for modeling desirable behavior and enforce the Code of Conduct consistently and equitably among the staff;
- •Develop and implement policies and procedures that address zero tolerance for intimidating and disruptive behaviors and non-retaliation clauses and policies to reduce the fear of intimidation;
- •Develop an organizational process for addressing intimidating and disruptive behavior;
- •Develop and implement a reporting system for detecting unprofessional behavior and possibly include an ombudsman service and patient advocates;
- •Support surveillance with tiered non-confrontational interventional strategies starting with informal "cup of coffee" conversations and moving toward more detailed action plans;
- •Document all attempts to address intimidating disruptive behavior.

The Sentinel Alert affirms the role of the medical staff in addressing disruptive behavior, stating that medical staff bylaws regarding physician behavior should be complementary

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and supportive of policies that are in place for the organization of the non-physician staff. The Sentinel Alert further states that medical staff credentialing standards requiring "interpersonal and communication skills" and "professionalism" be part of the privileging and credentialing process (2011 Joint Commission Standards, Introduction to Standard MS 06.01.03.)

NATIONAL PRACTITIONER DATA BANK

When considering the issue of disruptive behavior, it is important to keep in mind the requirements for reporting and to continually assess whether the specific instance in which you are dealing fits the mandate for report to either the National Practitioner Data Bank (NPDB) or to the Medical Board of California.

For purposes of the NPDB, a "professional review action" is defined as an action "… which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership" (42 U.S.C. §11151(9).) Accordingly, one of the first questions that must be answered is whether the disruptive behavior is related to professional competence or conduct. If so, then there are other provisions which restrict what is reported and they are not equivalent to the requirements for a report to the Medical Board of California.

The 2015 NPDB Guidebook requires reporting only if:

--actions are taken against all or any part of a practitioner's clinical privileges for a period of 30 days (42 U.S.C. § 11133(a)(1)(A); or

--if the practitioner resigns while under "investigation" or in return for not conducting an investigation. (42 U.S.C. § 11133(a)(1)(B).)

The term "investigation" is broadly defined. The NPDB indicates it should generally be the precursor to a profession review action. An investigation is one that is focused on a specific practitioner which concerns "the professional competence and/or professional conduct of the practitioner in question." It "begins with an inquiry" and does not end until the entity's decision-making authority takes final action or formally closes the investigation. While the NPDB may look at bylaws or other facility documents to determine if an investigation has started, the NPDB asserts it retains the ultimate authority to determine if an investigation commenced.

The NPDB takes the position a resignation under investigation must be reported even if the investigation later reveals no fault with the practitioner's professional competence or conduct. The NPDB suggests a Revision-to-Action Report is optional to clarify the situation for future queries.

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In addition, if a practitioner resigns while under investigation, a report must be filed, even if the practitioner was unaware of the fact the investigation was occurring. While the regulations governing the NPDB require practitioners be informed before an action is taken by a licensing board, there is no such requirement for a peer review body.

The Department also takes the position that an "adverse action to clinical privileges" includes the requirement that a proctor be present in order to perform a procedure. This is true, even if the proctor has no hand in the procedure or advising the physician regarding his performance.

The NPDB only mandates reports be filed that are related to actions taken against a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State. (42 U.S.C. §11151.8.) The NPDB provides that reports may be filed, but are not required to be filed, with regard to other health care providers. (42 U.S.C. 11133(a)(2).)

BUSINESS AND PROFESSIONS CODE SECTION 805

The Medical Board of California requires reports to be filed concerning physicians and surgeons (including residents), doctors of podiatric medicine, clinical psychologists, marriage and family therapists, clinical social workers, professional clinical counselors, dentists, or physician assistants. (Bus. & Prof. Code §805(a)(2).)

The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic must file an 805 report within 15 days after the effective date of certain specified actions, including when membership, staff privileges, or employment is terminated or revoked or where restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason. Accordingly, consideration will need to be given as to whether any recourse the Medical Staff may consider to address disruptive behavior qualifies as being taken "for a medical disciplinary cause or reason." It is also important to note that 805 reports are required to be filed when a licentiate resigns, takes a leave of absence or withdraws an application for reappointment. It is recommended that reference be made to the specific statutory language when facing a specific instance of disruptive behavior and consultation with legal counsel may be warranted to ensure compliance and to protect the medical staff from the risks that can result from situations of this nature.

For Appendix F:
Appendix F was prepared by the firms of Nossaman, LLP, and Procopio, Cory, Hargreaves & Savitch LLP

Although the information contained herein is provided by professionals at these firms, the content and information should not be used as a substitute for professional services. If legal or other professional advice is required, the services of a professional should be sought.

Draft
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