IMPAIRED AND/OR DISRUPTIVE PRACTITIONER POLICY

AND

POLICY PROHIBITING SEXUAL HARASSMENT AND OTHER FORMS OF HARASSMENT OF THE MEDICAL STAFF

AMENDED: December 2000
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ARTICLE I. PURPOSE AND USE OF THIS POLICY AND DEFINITIONS

1.1. Impaired and/or Disruptive Practitioner Policy

The Hospital and its Medical Staff have an obligation to protect patients from harm. In this regard, this policy is intended to provide guidelines for the identification, review, intervention, action and rehabilitation of physically or psychologically distressed or impaired, including substance and/or alcohol use or abuse, and/or disruptive Practitioners.

This process will identify and manage matters of individual practitioners’ health that is separate from the Medical Staff’s disciplinary function, and it will include an element of education about practitioner health, addressing prevention of physical, psychiatric or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation.

1.2. Policy Prohibiting Sexual Harassment and Other Forms of Harassment

The Hospital strives to provide a work environment where all employees can work together comfortably and productively, free from harassment. The Hospital also is committed to provide a work place free of sexual harassment. The Hospital prohibits harassment of any of its employees, regardless of whether that harassment is targeted specifically to the employee, based on an individual's race, religion, color, gender, age, national origin, ancestry, marital status, medical condition, sexual orientation, physical and mental disability or other factors. This Policy is intended to provide guidelines for the identification, review, intervention, action and rehabilitation of Practitioners who engage in conduct that constitutes harassment.

1.3. Use of This Policy

It is in the sole discretion of the Board and/or its Medical Staff to use or not use this Policy. This Policy is not intended to supersede or replace the corrective action or credentialing processes. It is within the sole discretion of the Board and/or its Medical Staff whether to impose corrective action or appoint or reappoint any Practitioner, including Practitioners who have or are suspected of having psychological or physical conditions which the Hospital and/or its Medical Staff believe may be detrimental to patient care, their professional practice or conduct, or Hospital operations, or which is or may be disruptive. However, the President shall determine in his discretion whether a review will be conducted under this Policy or whether the matter will be processed under other Medical Staff processes. Nothing in this Policy shall be construed to create or provide support for the existence of an employer/employee relationship between a Hospital employee and a Medical Staff appointee, between the Hospital and a Medical Staff appointee or control over Hospital employees by Medical Staff appointees.

1.4. Definitions

The definitions contained in the Medical Staff Bylaws shall apply to like terms contained in this Policy.

1.5. Hospital Policies

Nothing in this Policy is intended to replace, supersede or conflict with other Hospital policies. This Policy is intended to outline processes for review and action concerning complaints/reports of possible physical or psychological impairments and/or disruptive conduct and/or harassment by a Medical Staff appointee.
ARTICLE II. PHYSICAL OR PSYCHOLOGICAL IMPAIRMENTS

Physical and/or psychological impairment includes, but is not limited to, medical and psychological problems, substance and/or alcohol use or abuse, conditions which may be rehabilitated if appropriate treatment is received and physical conditions which may, as determined by the Hospital and its Medical Staff, present risk to patients, co-workers, and others who come into contact with the affected Practitioner.

ARTICLE III. DISRUPTIVE CONDUCT

Disruptive conduct includes verbal abuse, physical abuse and other behavior or professional conduct on the part of a Medical Staff appointee or others with delineated clinical privileges which, in the sole discretion of the Hospital and/or its Medical Staff is disruptive to hospital and/or Medical Staff operations or is inconsistent with norms of professional behavior or has the potential to have a negative impact on patient care.

ARTICLE IV. HARASSMENT

Prohibited harassment may include, but is not limited to, epithets, slurs, derogatory comments or jokes, intimidation, negative stereotyping, threats, assault or any physical interference with the employee's normal work or movement, directed at an individual employee, their relatives, friends or associates. Harassment may also include written or graphic material placed on walls, bulletin boards or elsewhere on the Hospital's premises or circulated in the work place that denigrates or shows hostility or aversion towards an individual or group because of the characteristics identified above.

Sexual harassment is defined as unwelcome sexual conduct of any nature that creates an offensive or hostile working environment or unwelcome sexual conduct that is made a condition with the involved Practitioner at the Hospital.

Prohibited sexual harassment includes unwelcome sexual conduct such as:

- Verbal harassment (e.g., sexual requests, comments, jokes, slurs);
- Physical harassment (e.g., physical contact); and
- Visual harassment (e.g., posters, cartoons or drawings of a sexual nature).

While the legal standards and consequences of sexual harassment are still evolving, the Hospital's policy has been and remains clear and more all encompassing than the law's requirement. This is because the Hospital's policy rests on the fundamental precept that each employee must treat all others with respect, dignity and professionalism. The Hospital requires this same standard from Medical Staff appointees. Deviation from that standard will not be tolerated.
ARTICLE V. PROCESS

5.1. Report and Identification of Physical or Psychological Impairments, Disruptive Conduct and/or Harassment

Concerns or suspicions regarding a possible physical or psychological impairment of and/or disruptive conduct and/or harassment by any Practitioner holding Medical Staff appointment and/or clinical privileges at the Hospital should be reported immediately in writing on the prescribed form to the President who shall review the matter. The form to be used and/or instructions for making reports for review under this Policy are available in the Medical Staff Office. If a Hospital employee reports a concern or makes a complaint to his supervisor, but refuses or otherwise fails to make a report to the President under this Policy, it is expected that the supervisor make the report to the President on the prescribed form. All individuals other than patients making a report under this Policy shall use the prescribed reporting forms. Patient complaints may, in the President's discretion, also be processed under this Policy. Patient complaints must be in writing, but a report form is not required.

5.2. President's Review

The President may seek additional information, interview witnesses, the Complainant and the Practitioner who is the subject of the complaint. After receiving a complaint/report of a possible physical or psychological impairment and/or disruptive conduct, the President may determine no further action(review is necessary and close the review if he determines the complaint/report is without basis. The President may also close a review of complaint/report of possible physical or psychological impairment and/or disruptive conduct by issuing a letter of warning, admonition or reprimand. The President may refer all complaints of harassment for review by an Ad Hoc Committee appointed by him and may refer complaints of possible physical or psychological impairments and/or disruptive conduct for review by an Ad Hoc Committee as he deems appropriate.

5.3. Ad Hoc Committee Review and Report

5.3.1. Appointment of Ad Hoc Committee

If the President determines further review is necessary and in the case of a report of alleged harassment, he shall appoint an Ad Hoc Committee that shall be instructed to initiate a review of the matter.

Any referral of a matter to an Ad Hoc Committee under this Policy shall include, if known, the following information:

a) the date and time of the questionable actions or conduct, or when the medical condition became known;

b) the nature of the actions or conduct and the names of any witnesses to the actions or conduct, or the nature of the medical condition;

c) whether the condition, actions or conduct affected or involved a patient in any way and, if so, the name and Hospital number of the patient;
d) the basis for questioning the actions or conduct, or for the concern with regard to the medical condition;

e) whether any action was taken at the time the questioned condition, action or conduct became known; and

f) a copy of the completed report form or patient complaint, as applicable.

5.3.2. Review

The Ad Hoc Committee may conduct the review in any manner it deems appropriate. It may use outside resources, such as the Colorado Physician Health Program, upon approval of the CEO. Any person authorized to take immediate corrective action may also impose immediate corrective action, as outlined in the Credentials and Hearing and Appellate Review Policy and Procedure Manual, pending completion of the review or investigation and action, as applicable. The President and/or the Ad Hoc Committee may refer the matter to the MEC with a request for investigation for potential corrective action. The MEC, in its discretion may conduct an investigation and may take precautionary corrective action, pending outcome of the review or investigation, as outlined in the Medical Staff Bylaws and/or any other bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital or its Medical Staff.

5.3.3. Report

The Ad Hoc Committee shall make whatever report it deems appropriate to the President for review and action. The report of the Ad Hoc Committee may suggest:

5.3.3.1. With regard to disruptive behavior:

a) that a discussion be conducted with the affected Practitioner to advise him of the problems identified, what is expected to occur in terms of the affected Practitioner's actions and conduct and what action, if any, is being recommended;

b) that an intervention be conducted;

c) that a letter of warning, reprimand or admonition be sent to the affected Practitioner;

d) that an investigation for potential corrective action be initiated, imposed or continued;

e) that conditions and/or limitations be placed on the affected Practitioner's Medical Staff appointment and/or clinical privileges; and/or

f) other action or recommendations as deemed appropriate by the Ad Hoc Committee.
5.3.3.2. With regard to a Practitioner with a medical or psychological condition or impairment:

   a) a discussion be conducted with the affected Practitioner to determine his/her level of awareness of the implications of the condition and what remedial steps he/she has taken and, to advise him of the range of possible recommendations;

   b) immediate intervention be conducted;

   c) conditions and/or limitations be imposed on the affected Practitioner's Medical Staff appointment and/or clinical privileges; and/or

   d) an investigation for potential corrective action be initiated, imposed or continued;

   e) other action or recommendations as deemed appropriate by the Ad Hoc Committee.

5.3.3.3. With regard to harassment:

   a) a discussion be conducted with the affected Practitioner to advise him of the problems identified, what is expected to occur in terms of the affected Practitioner's actions and conduct and what action, if any, is being recommended;

   b) an intervention be conducted;

   c) a letter of warning, reprimand or admonition be sent to the affected Practitioner;

   d) an investigation for potential corrective action be initiated, imposed or continued;

   e) conditions and/or limitations be placed on the affected Practitioner's Medical Staff appointment and/or clinical privileges; and/or

   f) other action or recommendations as deemed appropriate by the Ad Hoc Committee.

The report of the Ad Hoc Committee does not constitute an adverse action or recommendation and does not entitle the affected Practitioner to any of the procedural rights outlined in the Medical Staff Bylaws or other bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and/or its Medical Staff.
5.3.3.3.1. Action of the President after an Ad Hoc Committee Review and Report

The President shall review the report of the Ad Hoc Committee, and may request additional information, interviews with the affected Practitioner, witnesses and/or the Complainant and/or gather other information he deems necessary. The President may also defer action and refer the matter back to the Ad Hoc Committee with direction for further review and report.

After the President completes his review, he may take action. The action of the President may include, but is not limited to:

a) terminating the review and dismissing the matter;

b) issuance of a formal letter of admonition or reprimand;

c) proposing terms of training, education, consultation (other than concurring consultation), supervision, intensified review (including concurrent or retrospective review) or observation;

d) proposing terms for physical and/or psychological examination and/or evaluations;

d) proposing terms for treatment and/or monitoring; and

e) such other actions deemed appropriate by the President.

If the President determines that intervention, in the form of examination, evaluation, treatment and/or monitoring is necessary, he shall recommend treatment, monitoring and support, as he deems appropriate. The affected Practitioner may be referred to outside sources, such as the Colorado Physician Health Program. All costs for treatment, monitoring and support shall be the responsibility of the affected Practitioner.

The President may also refer the matter to the MEC for investigation for potential corrective action and may suggest restrictions or limitations on Medical Staff appointment and clinical privilege and/or leaves of absences, as he deems appropriate. The President, and/or other individuals as deemed appropriate by the President, shall meet with the affected Practitioner to present the President's action. If the Practitioner fails or refuses to agree to comply with the President's proposed action, the President shall refer the matter to the MEC with a request for initiation of an investigation for potential corrective action and/or such other action as the MEC deems appropriate.
The affected Practitioner shall not be entitled to procedural rights outlined in the Medical Staff Bylaws and/or other bylaws, policies, procedures, rules, regulations, manuals, guidelines and/or requirements of the Hospital or its Medical Staff as a result of the actions of the President under this Policy. Refusal or failure by the affected Practitioner to submit required reports or test results or to complete the agreed upon program shall be deemed to be a resignation of Staff appointment and/or clinical privileges and a waiver of the procedural rights outlined in the Medical Staff Bylaws and/or all other bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital or its Medical Staff and other rights to which the affected Practitioner may otherwise have been entitled.

5.3.3.6. Completion of Requirements

Once the affected Practitioner believes he has completed the requirements of the President's action, the affected Practitioner may submit a request for termination of monitoring and the requirements the affected Practitioner agreed to comply with, to the MEC. The MEC shall review the matter to determine whether the requirements of the President's action and/or restrictions in, limitations of, or leave of absence from Medical Staff appointment and/or limited privileges should be terminated. If the MEC denies the affected Practitioner's request in whole or in part, the affected Practitioner shall be notified in writing. The affected Practitioner shall be given ten (10) days to notify the MEC, through the Medical Staff Office, whether he will continue to comply with the requirements of the President's action or whether he wishes the MEC to take action or make a recommendation under Article VII, Section 7.3.3 of the Credentials and Hearing and Appellate Review Policy and Procedure Manual. If the MEC's recommendation or action pursuant to Article VII, Section 7.3 of the Credentials and Hearing and Appellate Review Policy and Procedure Manual is adverse, as defined in Article IX, Section 9.2.2 of the Credentials and Hearing and Appellate Review Policy and Procedure Manual, the affected Practitioner is entitled to exercise or waive the procedural rights as outlined in the Medical Staff Bylaws and/or all other bylaws, policies, procedures, rules, regulations, manuals, guidelines and requirements of the Hospital or its Medical Staff.

5.3.3.7. Failure to Cooperate

Failure or refusal to cooperate with a review under this Policy may result in an investigation and/or corrective action, as determined by the President, the MEC or the Board.

ARTICLE VI. PROFESSIONAL REVIEW

It is intended that the reviews, processes and actions outlined and authorized in this Policy are taken in the course of professional review and constitute professional review action. It is also intended that the professional review bodies, reviewers, participants and witnesses in the professional review processes outlined in this Policy and all professional review records and forms created, generated or reviewed pursuant to this Policy, be covered by the confidentiality, immunity and other protections available under applicable state and federal law.
ARTICLE VII. ADOPTION, AMENDMENT OR REPEAL

This policy may be adopted, amended or repealed upon approval of the MEC and the Board of the Hospital.

This IMPAIRED AND/OR DISRUPTIVE PRACTITIONER POLICY IS APPROVED AND ADOPTED by the Medical Executive Committee on November 17, 1998.

AMENDED by the MEC, December 2000.