WAKEMED

MEDICAL STAFF PROFESSIONALISM POLICY

TABLE OF CONTENTS

PAGE

PAGE

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PROFESSIONALISM POLICY

1. POLICY STATEMENT

1.A *Policy Objectives.*

(1) This Policy outlines progressive steps, beginning with collegial and educational efforts, which can be used by a hospital affiliated with WakeMed ("Hospital") and its Medical Staff Leaders to address conduct that does not meet expected standards. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve the concerns that have been raised in a constructive manner, and thus avoid the necessity of proceeding through the disciplinary process outlined in the Credentials Policy.

(2) This Policy is not intended to interfere with a Practitioner's ability to express, in a professional manner and in an appropriate forum:

(a) opinions on any topic that are contrary to opinions held by other Practitioners, Medical Staff Leaders, or Hospital personnel;

(b) disagreement with any Medical Staff or Hospital Bylaws, policies, procedures, proposals, or decisions; or

(c) constructive criticism of the care provided by any Practitioner, nurse, or other Hospital personnel.

1.B *Scope of Policy.*

(1) This Policy applies to all Practitioners (as defined in Section 1.D) who provide patient care services at the Hospital.

(2) If a matter involves both clinical and behavioral concerns, a Co-Chair of the Leadership Council and a Co-Chair of the WakeMed Committee for Professional Enhancement ("CPE") shall coordinate the reviews. The behavioral concerns may either be:

(a) addressed by the Leadership Council pursuant to this Policy, with a report to the CPE; or

(b) addressed by the CPE as part of its review under the Professional Practice Evaluation Policy, using the provisions in this Policy for guidance.

(3) All efforts undertaken pursuant to this Policy are part of the Hospital's performance improvement and professional practice evaluation/peer review activities.

(4) A flow chart depicting the review process for concerns regarding professional conduct pursuant to this Policy is attached as **Appendix A**.

1.C ***Expectations for Professional Conduct/Culture of Safety.*** Communication, collegiality, and collaboration are essential for the provision of safe and competent patient care. As such, all Practitioners must treat others with respect, courtesy, and dignity, and conduct themselves in a professional and cooperative manner.

In dealing with incidents of inappropriate conduct, the following are paramount considerations:

(1) the protection of patients, employees, Practitioners, and others and the orderly operation of the Medical Staff and Hospital;

(2) compliance with the law and providing an environment free from harassment and other forms of discrimination; and

(3) assisting Practitioners in resolving conduct issues in a constructive, educational, and successful manner.

1.D ***Definitions.***

(1) "Formal Collegial Intervention" means a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. Formal Collegial Intervention only occurs after a Practitioner has had an opportunity to provide input regarding a concern. If the Formal Collegial Intervention results from a matter that has been reported to the PPE Support Staff and reviewed through this Policy, it shall be followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the Practitioner's future practice in the Hospital. A copy of the follow-up letter will be included in the Practitioner's file along with any response that the Practitioner would like to offer.

In contrast, informal discussions, mentoring, counseling, and similar efforts that do not meet the criteria for a Formal Collegial Intervention are referred to as "initial collegial leadership efforts." This Policy encourages the use of initial collegial leadership efforts to assist Practitioners in continually improving their practices. There is no expectation that input be obtained prior to initial collegial leadership efforts or that such efforts be documented.

(2) "Employed Practitioner" means a Practitioner who is employed by an:

(a) WakeMed;

(b) Wake Specialty Physicians, LLC, WakeMed Specialist Group, LLC, and its controlled or related affiliates ("WMSP");;

(c) any other WakeMed-related entity that has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; or

(d) a private group that has: (i) a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; and (ii) information sharing provisions in a professional services contract or in a separate agreement with the Hospital.

(3) "Medical Staff Leader" means any Medical Staff Officer, Department Chair, Section Chief, or committee chair.

(4) "Practitioner" means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Advanced Practice Providers.

(5) "PPE Support Staff" means the clinical and non-clinical staff who support the professional practice evaluation ("PPE") process generally and the review of issues related to professionalism described in this Policy. This may include, but is not limited to, staff from the quality department, Medical Staff office, and/or patient safety department.

2. EXAMPLES OF INAPPROPRIATE CONDUCT. To aid in both the education of Practitioners and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

(a) abusive or threatening language or actions directed at patients, nurses, students, volunteers, visitors, Hospital personnel, or Practitioners (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);

(b) degrading, demeaning, or condescending comments or actions regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital;

(c) refusal or failure to: (i) answer questions; (ii) return phone calls or pages; or (iii) respond when on call for the Emergency Department in a timely manner as defined in the Medical Staff Bylaws documents or other applicable policies;

(d) intentional misrepresentation to Hospital administration, Medical Staff Leaders, other Practitioners, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken;

(e) offensive language (which may include profanity or similar language) while in the Hospital and/or while speaking with patients, nurses, or other Hospital personnel;

(f) retaliating against any individual who may have reported a quality and/or behavior concern about a Practitioner, provided information related to such a matter, or otherwise been involved in the professional practice evaluation/peer review process in any way (this means a Practitioner may not, under any circumstances, discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual);

(g) inappropriate physical contact with another individual or other aggressive behavior that is threatening or intimidating;

(h) throwing an object of any kind, including but not limited to any medical/surgical instrument or supply;

(i) repeatedly failing to renew legally-required credentials prior to expiration;

(j) derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff and/or Hospital administrative channels;

(k) inappropriate medical record entries impugning the quality of care being provided by the Hospital, Practitioners, or any other individual, or criticizing the Hospital or the Hospital's policies or processes, or accreditation and regulatory requirements;

(l) imposing idiosyncratic requirements on Hospital staff that have no impact on improved patient care, but serve only to burden the Hospital or Hospital employees with "special" techniques and procedures;

(m) altering or falsifying any medical record entry or hospital document (including, but not limited to, incorrectly dating or timing an entry or document to give the impression it was completed prior to when it was actually completed);

(n) completing medical record entries based on a template without considering the care actually provided to the patient, or using the "copy and paste" or "pull forward" functions of the medical record to populate fields without verifying that the information is accurate for the patient in question;

(o) refusal or failure to use or use properly documentation technology (e.g., CPOE, EHR, and other approved technology);

(p) inappropriate access, use, disclosure, or release of confidential patient information;

(q) audio, video, or digital recording that is not consented to by others present, including patients and other members of the care team;

(r) use of social media in a manner that involves inappropriate conduct as defined in this Policy or other Medical Staff or Hospital policies;

(s) disruption of hospital operations, hospital or medical staff committees, or departmental affairs;

(t) disregard of or refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, Credentials Policy, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call issues, response times, medical recordkeeping, other patient care responsibilities, failure to participate on assigned committees, failure to cooperate with utilization oversight activities, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and Hospital employees); and/or

(u) engaging in identity-based harassment as described in Section 8 of this Policy.

3. GENERAL GUIDELINES/PRINCIPLES

3.A ***Immediate Referrals to Medical Executive Committee.*** This Policy outlines collegial and progressive steps (e.g., counseling, warnings, meetings, and behavior modification education) that can be taken to address concerns about inappropriate conduct by Practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Medical Executive Committee or the elimination of any particular step in the Policy.

3.B ***Coordination with Other Policies That Govern Professional Conduct.*** If a report of inappropriate behavior involves an issue that is also governed by another Hospital policy that governs professional conduct (including, but not limited to, alleged violations of the Hospital's HIPAA or corporate compliance policies by a Practitioner), the President of the Medical Staff, Chief Medical Officer or WakeMed Medical Staff Officer and Senior Vice President of Quality will notify the person or committee responsible for that other policy of the substance of the report. Efforts will be made to coordinate the review that occurs under this Policy with the review under such other policy. For example, individuals responsible for such other policies (such as the Hospital's HIPAA Privacy Officer or Corporate Compliance Officer) may be invited to take part in the witness interviews described in this Policy or may discuss the matter with the Leadership Council or its representatives.

3.C ***No Legal Counsel or Recordings During Collegial Meetings.***

(1) To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings.

(2) No recording (audio or video) of a meeting shall be permitted or made. Smart phones, iPads, and similar devices must be left outside the meeting room.

3.D ***Education Regarding Appropriate Professional Behavior.*** Medical Staff and Hospital leaders shall educate all Practitioners regarding appropriate professional behavior, make employees and other personnel aware of this Policy, and shall encourage the prompt reporting of inappropriate conduct.

3.E ***Delegation of Functions.*** When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.

3.F ***Just Culture*****.** The Just Culture Algorithm for Physicians should be used to assist in making determinations required by this Policy, including whether behavior constitutes inappropriate conduct and the appropriate response to such behavior.

3.G ***Supervising Physicians and Advanced Practice Providers.*** A physician who is the primary supervising physician for an Advanced Practice Provider shall be kept apprised of any concerns with the Advanced Practice Provider that are reviewed pursuant to this Policy. Without limiting the foregoing, the supervising physician will be copied on all correspondence that an Advanced Practice Provider is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising physician shall maintain in a confidential manner all information related to reviews under this Policy.

4. REPORTING OF INAPPROPRIATE CONDUCT AND INITIAL REVIEW

4.A ***Reports of Inappropriate Conduct.*** Any Hospital employee or Practitioner who observes, or is subjected to, inappropriate conduct by a Practitioner shall report the incident in a timely manner by submitting a completed Professional Conduct Reporting Form to the PPE Support Staff (see **Appendix B**) or through some other approved Hospital reporting mechanism. The PPE Support Staff shall log the referral into the confidential peer review database.

4.B ***Follow-up with Individual Who Filed Report.*** The PPE Support Staff, Chief Medical Officer, or WakeMed Medical Staff Officer and Senior Vice President of Quality should follow up with individuals who file a report when possible by:

(1) thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care;

(2) informing them that:

(i) the matter will be reviewed in accordance with this Policy and that they may be contacted for additional information;

(ii) due to confidentiality requirements under North Carolina law, it is important that they maintain confidentiality and only discuss the matter with individuals who are a formal part of the review process;

(iii) due to these same confidentiality requirements, the Hospital is not permitted to disclose the outcome of the review to them, but they can be assured that a thorough review will be conducted; and

(iv) no retaliation is permitted against any individual who raises a concern and they should immediately report any retaliation or any other incidents of inappropriate conduct.

A letter or email that can be used for this purpose is attached as **Appendix C**. As an alternative to sending a letter or email, the content of **Appendix C** and the provisions outlined above in this section may be used as talking points to discuss these issues verbally with the individual who reported a concern.

4.C ***Initial Triage.*** The President of the Medical Staff, Chief Medical Officer, and/or WakeMed Medical Staff Officer and Senior Vice President of Quality will review the circumstances as reported and determine to proceed in one of the following two ways:

(1) ***Conduct additional fact-finding*** to determine if the reported concern is credible and further action is necessary. In such case, the President of the Medical Staff, Chief Medical Officer, and/or WakeMed Medical Staff Officer and Senior Vice President of Quality will follow the steps set forth in Section 4.F of this Policy; or

(2) ***Resolve informally and promptly*** because the allegations as reported, even if true, do not rise to the level that further review under this Policy is necessary because: (1) the concern is minor in nature; and (2) there is no history or pattern with the Practitioner in question.

For matters that qualify for informal resolution, the President of the Medical Staff, Chief Medical Officer, and/or WakeMed Medical Staff Officer and Senior Vice President of Quality will speak with the Practitioner about the concern and either dismiss the matter altogether (if the concern does not appear credible based on the Practitioner's input) or counsel the Practitioner. If the Practitioner is counseled, the President of the Medical Staff, Chief Medical Officer or WakeMed Medical Staff Officer and Senior Vice President of Quality will follow up with a brief note to the Practitioner or a brief note to the file memorializing the conversation.

The initial triage that occurs pursuant to this section may be documented in the electronic reporting system.

4.D ***Employed Practitioner Triage.***

(1) If a reported concern about behavior: (i) is not resolved informally as set forth in Section 4.C(2); and (ii) involves an Employed Practitioner, then Medical Staff

Leaders will consult with appropriate representatives of the Employer (as defined below) and then determine which of the two processes described in this Section will be used for the review (a form that may be used to document this decision is attached as **Appendix D**).

(2) The reported concern may be reviewed under either the Medical Staff process or the Employer's process, as follows:

(a) If the matter will be reviewed using the Medical Staff process as set forth in this Policy, an appropriate representative of the Employer (as defined below) may be invited to attend relevant portions of committee meetings involving the Practitioner, as well as participate in any interventions that may be necessary following the review. The chair of the Leadership Council may recuse the representative of the Employer during any deliberations or vote on a matter. Documentation from the Medical Staff process will not be disclosed to the Employer for inclusion in the employment file, but the Employer will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities; or

(b) If the matter will be reviewed by the Employer pursuant to its policies and/or the relevant contract:

(i) the Medical Staff process shall be held in abeyance and the Leadership Council notified;

(ii) the PPE Support Staff will assist the Employer with witness interviews, document review, data compilation, and similar fact-finding. Documentation of such fact-finding will be maintained in the Practitioner's confidential Medical Staff peer review/quality file consistent with the state peer review statute, but the Employer will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities;

(iii) the Leadership Council will be kept informed of the progress and outcome of the review by the Employer; and

(iv) the Leadership Council may choose, at any time and in its sole discretion, that the matter shall also be reviewed pursuant to this Policy. However, neither such a review by the Leadership Council nor any other provision of this Policy shall be interpreted to affect the right of the Employer to take any action authorized by the relevant contract with the Practitioner.

(3) For purposes of this Section, an "appropriate representative of the Employer" includes individuals with employment responsibilities (if WakeMed or the

Hospital is the Employer), or a peer review committee within the Employer (if the Employer is a Hospital-related entity or a qualifying private group).

4.E ***Preliminary Notification to Practitioner.*** If a reported concern about behavior is not resolved informally as set forth in Section 4.C(2), the President of the Medical Staff, Chief Medical Officer, or WakeMed Medical Staff Officer and Senior Vice President of Quality should notify the Practitioner that a concern has been raised and the matter is being reviewed. Generally, this preliminary communication should occur via a telephone call or a personal discussion as soon as practical. The Practitioner should be notified that he or she will be invited to provide input regarding the matter if the facts underlying the incident are determined to be credible, but that he or she is also free to submit input at any time. The Practitioner should also be reminded to avoid any action that could be perceived as retaliation (including any attempt to discuss the matter with an individual who the Practitioner believes may have raised the concern or provided information about it). Instructions and a form that may be used to help prepare for and document the preliminary notification described in this section are attached as **Appendix E**.

4.F ***Additional Fact-Finding to Determine Credibility.*** If a matter is not resolved informally as set forth in Section 4.C(2), the PPE Support Staff, Chief Medical Officer, WakeMed Medical Staff Officer and Senior Vice President of Quality, and/or President of the Medical Staff shall interview witnesses or others who were involved in the incident, and gather any other necessary documentation or information (e.g., interviews with core leaders or nurse/area leaders) needed to assess the credibility of the report. **Appendix F** contains a script that may be used for interviews, along with sample interview questions.

(a) ***Report <u>Not</u> Credible.*** Any determination that a report is not credible must be made by at least two of these individuals: Chief Medical Officer, WakeMed Medical Staff Officer and Senior Vice President of Quality, and President of the Medical Staff. In such case, the matter shall be closed and the Practitioner will be notified of this determination. The individual who filed the report may be notified that the report was not substantiated, at the discretion of the Leadership Council. Intentionally false reports will be grounds for disciplinary action. False reports by Practitioners will be referred to the Leadership Council, while false reports by Hospital employees will be referred to human resources.

(b) ***Report Credible, Further Review Required.*** Either the Chief Medical Officer, WakeMed Medical Staff Officer and Senior Vice President of Quality, or President of the Medical Staff may determine that a report is credible and that the matter should be reviewed further in accordance with this Policy. In such case, input will be obtained from the Practitioner as set forth in Section 5. The PPE Support Staff shall then prepare a summary report of the matter for review by the Leadership Council.

The Leadership Council will be notified of determinations made pursuant to this subsection, to allow it to conduct oversight and monitor the process for consistency.

5. OBTAINING INPUT FROM THE PRACTITIONER

5.A ***General.*** For reports that are determined to be credible and require further review under this Policy, the President of the Medical Staff, Chief Medical Officer, WakeMed Medical Staff Officer and Senior Vice President of Quality, and/or PPE Support Staff will provide details of the concern to the Practitioner and ask the Practitioner to provide a written explanation of what occurred and his or her perspective on the incident.

5.B ***Identity of Reporter.***

(1) ***General Rule.*** Since this Policy does not involve disciplinary action or "restrictions" of privileges, the specific identity of the individual reporting a concern or otherwise providing information about a matter (the "reporter") generally will not be disclosed to the Practitioner.

(2) ***Exceptions.***

(a) ***Consent.*** The Leadership Council may, in its discretion, disclose the identity of the reporter to the Practitioner if the reporter specifically consents to the disclosure (with the reporter being reassured that he or she will be protected from retaliation).

(b) ***Medical Staff Hearing.*** The identity of the reporter shall be disclosed to the Practitioner if information provided by the reporter is used to support an adverse professional review action that results in a Medical Staff hearing.

(3) ***Practitioner Guessing the Identity of Reporter.*** This section does not prohibit the Leadership Council from notifying a Practitioner about a concern that has been raised even if the description of the concern would allow the Practitioner to guess the identity of the reporter (e.g., where the reporter and the Practitioner were the only two people present when an incident occurred). In such case, the Leadership Council will not confirm the identity of the reporter, and will pay particular attention to reminding the Practitioner to avoid any action that could be perceived as retaliation.

5.C ***Confidentiality.*** The Practitioner must maintain all information related to the review in a strictly confidential manner, as required by North Carolina law. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the written permission of the Leadership Council, except for any legal counsel who may be advising the Practitioner.

5.D ***Retaliation.*** The Practitioner may not retaliate against anyone who he or she believes may have raised a concern, provided information regarding the matter, or otherwise been involved in the review process. This means a Practitioner may not, under any circumstances, discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or

discriminating against such individual. If a Practitioner wishes to offer an apology to any individual, the Practitioner must contact the Leadership Council and comply with its requirements regarding the manner in which the apology is provided.

5.E ***Reminder of Practitioner's Obligations.*** The PPE Support Staff, Chief Medical Officer, WakeMed Medical Staff Officer and Senior Vice President of Quality, or President of the Medical Staff will remind the Practitioner of the obligations set forth in this section as part of seeking his or her input. A cover letter similar to the one set forth in **Appendix G** shall be used for this purpose. The Practitioner may also be asked to sign the "Confidentiality and Non-Retaliation Agreement" that is attached as **Appendix H** before such a letter is sent if there are particular concerns about maintaining confidentiality or ensuring a professional, non-threatening environment for the individuals involved in a specific situation.

5.F ***Discussions Outside Committee Meetings*.** Practitioners and individual members of the Leadership Council should not engage in separate discussions of a matter unless the Leadership Council has asked the individual committee member to speak with the Practitioner on its behalf. Similarly, unless formally requested to do so, Practitioners may not provide verbal input to a PPE Specialist or to any other individual and ask him or her to relay that verbal input to the Leadership Council. The goal of these requirements is to ensure that all individuals and committees involved in the review process receive the same, accurate information. Finally, Practitioners must refrain from any discussions or lobbying with other Medical Staff members or Board members outside the authorized review process outlined in this Policy.

6. LEADERSHIP COUNCIL PROCEDURE

6.A ***Initial Review.*** The Leadership Council shall review the summary prepared by the PPE Support Staff and all supporting documentation, including the response from the Practitioner. If necessary, the Leadership Council may also meet with the individual who submitted the report and/or any witnesses to the incident. If it determines that it would be necessary or helpful in addressing the reported concern, the Leadership Council may also consult with or include the appropriate Department Chair in the review or may appoint an ad hoc committee to review the incident and report back to it.

6.B ***Meeting Between Practitioner and Leadership Council.*** A meeting may be held between the Practitioner and the Leadership Council to discuss the circumstances further if either the Leadership Council or the Practitioner believes that such a meeting would be helpful prior to the Leadership Council concluding its review and making a determination. In their discretion, the Leadership Council Co-Chairs may designate one or more committee members to attend the meeting rather than the full committee, regardless of who requested the meeting. The Leadership Council may also obtain additional written input from the Practitioner using the process set forth in Article 5.

6.C ***Leadership Council's Determination and/or Intervention.***

(1) Based on all of the information received, the Leadership Council may:

(a) determine that no further review or action is required;

(b) send the Practitioner a letter of guidance or counsel;

(c) send the Practitioner a letter of warning or reprimand;

(d) engage in a Formal Collegial Intervention with the Practitioner as described in the Definitions section of this Policy, with such meeting being documented via a memo or letter to the Practitioner that is maintained in the Practitioner's file;

(e) develop a Performance Improvement Plan for Conduct, as described in Section 6.D below; or

(f) refer the matter to the Medical Executive Committee.

(2) The Leadership Council shall inform the relevant Department Chair of its determination and intervention.

(3) Any of the determinations or interventions described above may include education and coaching efforts with the Practitioner, including, when appropriate, education about administrative channels that are available for registering concerns about quality or services, if the Practitioner's conduct suggests that such concerns led to the behavior. Other sources of support may also be identified for the Practitioner, if appropriate.

6.D ***Performance Improvement Plan for Conduct.***

(1) ***General.*** The Leadership Council may determine it is necessary to develop a Performance Improvement Plan ("PIP") for the Practitioner to bring about sustained improvement in the individual's behavior. One or more members of the Leadership Council should personally discuss the PIP with the Practitioner to help ensure a shared and clear understanding of the elements of the PIP. The PIP will also be presented in writing, with a copy being placed in the Practitioner's file, along with any statement the Practitioner would like to offer.

(2) ***Voluntary Nature of PIPs.*** If a Practitioner agrees to participate in a PIP developed by the Leadership Council, such agreement will be documented in writing. If a Practitioner disagrees with the need for a PIP developed by the Leadership Council, the Practitioner is under no obligation to participate in the PIP. In such case, the Leadership Council cannot compel the Practitioner to agree with the PIP. Instead, the Leadership Council will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Credentials Policy.

(3) ***PIPs Not Disciplinary.*** PIPs are part of the Hospital's performance improvement and professional practice evaluation/peer review process. PIPs are not disciplinary in nature. Because a PIP is recommended by a non-disciplinary

committee that has no authority to restrict privileges and is voluntarily accepted by the Practitioner, the PIP is not reportable to the National Practitioner Data Bank or any state licensing board.

(4) ***PIP Options.*** A PIP for conduct may include, but is not limited to, one or more of the actions in this Section. None of these actions entitles the Practitioner to a hearing or appeal as described in the Credentials Policy, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank. **Appendix I** provides additional guidance regarding these and other PIP options for conduct and their related implementation issues.

(a) ***Meeting with Designated Group.*** The Practitioner may be required to meet with a designated group (including the CPE, another Medical Staff committee, or an ad hoc group) to discuss the concerns with the Practitioner's conduct and the need to modify the conduct. An ad hoc group may include any combination of current or past Medical Staff Leaders, Hospital leaders, outside consultants, and/or the Board Chair or other Board members if the Leadership Council determines that Board member involvement is reasonably likely to impress upon the Practitioner involved the seriousness of the matter and the necessity for the Practitioner's conduct to improve. A letter outlining the discussion and expectations for conduct shall be sent to the Practitioner after the meeting;

(b) ***Periodic Meetings with Medical Staff Leaders or Mentors.*** The Practitioner may be required to meet periodically with one or more Medical Staff Leaders or a mentor designated by the Leadership Council. The purpose of these meetings is to provide input and updates on the Practitioner's performance, as well as to offer assistance and support with any challenging issues the Practitioner may be encountering;

(c) ***Review of Literature Concerning the Connection Between Behavior and Patient Safety.*** The Leadership Council may require the Practitioner to review selected literature concerning the established connection between behavior and patient care and safety and then provide a report to the Leadership Council summarizing the information reviewed and how it can be applied to the individual's practice;

(d) ***Behavior Modification Course.*** The Leadership Council may require the Practitioner to complete a behavior modification course that is acceptable to the Leadership Council;

(e) ***Personal Code of Conduct.*** The Leadership Council may develop a "personal" code of conduct for the Practitioner, make continued appointment and clinical privileges contingent on the Practitioner's adherence to it, and outline the specific consequences of the Practitioner's failure to abide by it; and/or

(f) ***Other.*** Elements not specifically listed above may be included in a PIP. The Leadership Council has wide latitude to tailor PIPs to the specific concerns identified, always with the objective of helping the Practitioner to improve his or her performance and to protect patients and staff.

6.E ***Practitioner's Refusal to Provide Information or Meet with Leadership Council.***

(1) If the Practitioner fails or refuses to provide written input in response to a request for information sent by the Leadership Council, the Practitioner will be required to meet with the Leadership Council. The purpose of the meeting is to discuss the Practitioner's obligation to participate in the review process, permit the Practitioner to explain why the information was not provided, and inform the Practitioner of the consequences of continuing to not provide the information. Failure of the Practitioner to either:

(a) meet with the Leadership Council and persuade it that the requested information is not necessary; or

(b) provide the requested written information prior to the meeting

will result in the automatic relinquishment of the Practitioner's clinical privileges. Such automatic relinquishment will continue until the Practitioner either meets with the Leadership Council and persuades it that the written information is not necessary or provides the requested written information.

(2) If the Leadership Council requests that the Practitioner attend a meeting with it or a designated individual for any reason (e.g., to obtain the Practitioner's verbal input, participate in a Collegial Intervention, etc.) and the Practitioner fails or refuses to attend such a meeting, the Practitioner's clinical privileges will be automatically relinquished until the meeting occurs.

(3) If the Practitioner fails to meet with and provide input requested by the Leadership Council within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

(4) The automatic relinquishment or resignation of appointment and/or clinical privileges described in this section are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

6.F ***Letters Placed in Practitioner's Confidential File.*** Copies of letters sent to the Practitioner as part of the efforts to address the Practitioner's conduct shall be placed in the Practitioner's confidential file. The Practitioner shall be given an opportunity to respond in writing, and the Practitioner's response shall also be kept in the Practitioner's confidential file.

6.G ***Additional Reports of Inappropriate Conduct.*** If additional reports of inappropriate conduct are received concerning a Practitioner, the Leadership Council may continue to use the collegial and progressive steps outlined in this Section 6 as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

6.H ***Determination to Address Concerns through Practitioner Health Policy.*** The Leadership Council may determine to address the conduct concerns through the Practitioner Health Policy if it believes that there may be a legitimate, underlying health issue that is causing the concerns, and the review process outlined in the Practitioner Health Policy is more likely to resolve the concerns.

7. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

7.A ***Referral to the Medical Executive Committee.*** At any point, the Leadership Council may refer the matter to the Medical Executive Committee for review and action because:

(1) the Practitioner refuses to participate in a Performance Improvement Plan developed by the Leadership Council;

(2) the Performance Improvement Plan options for conduct were unsuccessful; or

(3) the Leadership Council otherwise determines that Medical Executive Committee review is required.

The Medical Executive Committee shall be fully apprised of the actions taken previously by the Leadership Council to address the concerns. When it makes such a referral, the Leadership Council may also suggest a recommended course of action.

7.B ***Medical Executive Committee Review.*** The Medical Executive Committee shall review the matter and take appropriate action in accordance with the Credentials Policy. These actions include all of the Performance Improvement Plan options set forth in **Appendix I**, as well as short-term suspensions, long-term suspensions, and/or the revocation of appointment and clinical privileges, subject to any procedural rights as set forth in the Credentials Policy.

8. REVIEW OF REPORTS OF IDENTITY-BASED HARASSMENT

8.A ***Definition.***

(1) Identity-based harassment is verbal or physical conduct that: (i) is unwelcome and offensive to an individual who is subjected to it or who witnesses it; (ii) could be considered harassment from the objective standpoint of a "reasonable person"; and (iii) is covered by state or federal laws governing discrimination. Identity-based harassment includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination.

(2) Depending on the circumstances, any of the examples of inappropriate conduct described in Section 2 of this Policy may also qualify as identity-based harassment. Additional examples of identity-based harassment include, but are not limited to, the following:

(a) ***Verbal:*** innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and suggestive or insulting sounds;

(b) ***Visual/Non-Verbal:*** derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and obscene gestures;

(c) ***Physical:*** unwanted physical contact, including touching, interference with an individual's normal work movement, and assault;

(d) ***Quid Pro Quo:*** suggesting that submission to an unwelcome sexual advance will lead to a positive employment action or avoid a negative employment action; and

(e) ***Retaliation:*** retaliating or threatening retaliation as a result of an individual's complaint regarding harassment.

(3) Tests and standards used by courts to determine if conduct violates federal or state law (e.g., Title VII of the Civil Rights Act) are <u>not</u> dispositive in determining whether conduct is "inappropriate conduct" for purposes of this Policy. Instead, the standard set forth in this section shall govern, as interpreted by the Leadership Council, Medical Executive Committee, and/or Board of Directors. The intent of this provision is to create higher expectations for professional behavior than the minimum required by federal and state law.

8.B ***General.*** All reports of potential identity-based harassment will be reviewed by the Leadership Council in the same manner as outlined earlier in this Policy. In addition, while a Practitioner may be asked to voluntarily refrain from exercising clinical privileges pending the review of any behavioral matter under this Policy, particular attention will be paid to determining if an agreement to voluntarily refrain is appropriate while an allegation of identity-based harassment is being reviewed.

8.C ***Personal Meeting and Letter of Admonition and Warning.*** Because of the unique legal implications surrounding identity-based harassment, a single confirmed incident requires the actions set forth in this section. Two or more members of the Leadership Council shall personally meet with the Practitioner to discuss the incident. If the Practitioner acknowledges the seriousness of the matter and agrees that there will be no repeat of such conduct, the meeting shall be followed with a formal letter of admonition and warning to be placed in the Practitioner's confidential file. This letter shall also set forth any additional actions or conditions imposed on the Practitioner's continued practice in the Hospital as a result of the meeting.

8.D ***Performance Improvement Plan*.** In addition to the letter of admonition and warning, concerns about identity-based harassment may also be addressed by a Performance Improvement Plan for conduct as described in this Policy.

8.E ***Referral to Medical Executive Committee.*** The matter shall be immediately referred to the Medical Executive Committee if:

(1) the Practitioner refuses to acknowledge the concern, does not recognize the seriousness of it, or will not agree that there will be no repeat of such conduct; or

(2) there are confirmed reports of retaliation or further incidents of identity-based harassment, after the Practitioner agreed there would be no further improper conduct.

The Medical Executive Committee shall conduct its review in accordance with the Medical Staff Credentials Policy. Such referral shall not preclude other action under applicable Human Resources policies.

Approved by the Cary & Raleigh Medical Executive Committees on March 28, 2019.
5/13/2021 Professional Issue Summary Form replaced upon approval of Leadership Council.

APPENDIX B

PROFESSIONAL CONDUCT REPORTING FORM

For Use by Employees and Practitioners

Instructions: Please use this form to report all incidents of inappropriate conduct and unprofessional behavior. Attach additional sheets if necessary. Please provide the following information as ***specifically*** and as ***objectively*** as possible and submit the completed form to the Hospital PPE Support Staff.

DATE, TIME, AND LOCATION OF INCIDENT			
Date of incident:	Time of incident:	a.m.	
		p.m.	
Location of incident:			
Range of dates if your concerns are not limited to one particular event: _____/_____/20_____ to _____/_____/20_____			
PRACTITIONER INFORMATION			
Name of Practitioner exhibiting inappropriate professional conduct: _____			
PATIENT INFORMATION			
Was a patient directly or indirectly involved in the event?	**Yes** ❑	**No** ❑	Medical Record # _____
Patient's Last Name: _____		Patient's First Name: _____	
DESCRIPTION OF INCIDENT			
Describe what happened as *specifically* and *objectively* as possible [attach additional pages if necessary]: _____ _____ _____			
OTHER INDIVIDUALS INVOLVED/WITNESSES			
Name(s) of other Practitioner(s) and/or Hospital employee(s) who witnessed this event: _____ _____ _____ _____			
Name(s) of any other person(s) who were involved in or witnessed this event (e.g., visitors; family members, representatives): _____ _____ _____ _____			

EFFECT OF CONDUCT		
How do you think this behavior affected patient care, Hospital operations, your work, or your team members' work? _____ _____ _____		
	Yes	**No**
Did you experience or witness any retaliation or threatened retaliation by the Practitioner?	❑	❑
If yes, please explain: _____ _____ _____		
RESPONSE TO CONDUCT	**Yes**	**No**
Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?	❑	❑
If yes, please explain and indicate by whom: _____ _____ _____		

CONTACT INFORMATION	
Your name:	Department:
Phone #:	Date this form completed:
E-mail address:	

Note: Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless: (a) you consent; or (b) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence). In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the Practitioner at issue may not approach you directly to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report that immediately to your supervisor, the President of the Medical Staff, or another Medical Staff leader.

APPENDIX C

LETTER TO RESPOND TO INDIVIDUAL WHO REPORTS AN INCIDENT OF INAPPROPRIATE CONDUCT*

Dear _____:

Thank you for reporting your concerns. We appreciate your participation in our efforts to promote and maintain a culture of safety and quality care at our Hospital.

Your concerns will be reviewed in accordance with the Medical Staff Professionalism Policy or other applicable policy. We will contact you if we need additional information.

Because your report may involve confidential matters under North Carolina law, it is important that you maintain confidentiality and only discuss this matter with individuals who are a formal part of the review process. Due to these same confidentiality requirements, we may not be permitted to inform you of the specific outcome of the review. However, please be assured that your report will be fully reviewed and appropriate steps will be taken to address the matter.

Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless:

(a) you consent; or

(b) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence).

In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the individual who is the subject of your report may not approach you directly to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report that immediately to *[me/the PPE Support Staff, Chief Medical Officer, or WakeMed Medical Staff Officer and Senior Vice President of Quality]*.

Once again, thank you for bringing your concerns to our attention. If you have any questions or wish to discuss this matter further, please do not hesitate to call me at _____.

Sincerely,

PPE Support Staff, President of the Medical Staff, Chief Medical Officer, or WakeMed Medical Staff Officer and Senior Vice President of Quality

***** ***As an alternative to sending a letter or email, the content of this Appendix may be used as talking points to respond verbally to the individual who reported a concern regarding conduct.***

APPENDIX D

EMPLOYED PRACTITIONER ROUTING FORM

***Note**: The purpose of this form is to document which of the following two review processes will be used when a behavioral concern is raised about an Employed Practitioner: (1) the Medical Staff process as set forth in this Professionalism Policy; or (2) the policies or employment contract of the Employer. See Section 4.D of this Professionalism Policy for additional information and requirements.*

Name of Practitioner: _____

Entity that employs the Practitioner: _____

Representative(s) of Employer involved in routing discussion: _____

_____

Medical Staff Leader(s) involved in routing discussion: _____

_____

A decision was made that:

- ❑ The process outlined in the ***Medical Staff Professionalism Policy*** will be used to review the behavioral concern.
- ❑ ***The Employer's policies and/or employment contract*** will be used to review the behavioral concern.

Comments: _____

_____

_____

_____

Signature of individual completing form

_____

Date

APPENDIX E

PRELIMINARY NOTIFICATION TO PRACTITIONER (INSTRUCTIONS AND FORM)

I. PREPARATION PRIOR TO CONVERSATION BY INDIVIDUAL PROVIDING PRELIMINARY NOTIFICATION (President of the Medical Staff, Chief Medical Officer, or WakeMed Medical Staff Officer and Senior Vice President of Quality)

1. Review Section 4.E of the Professionalism Policy ("Preliminary Notification to the Practitioner").

2. Decide whether to provide preliminary notification in person or over the telephone. *E-mail is strongly discouraged*.

3. If the President of the Medical Staff, Chief Medical Officer or WakeMed Medical Staff Officer and Senior Vice President of Quality is not able to provide preliminary notification in a timely manner, Section 3.F of the Professionalism Policy permits delegation of this function to a qualified designee.

4. Be cognizant that no information should be provided to the Practitioner during the discussion that would identify anyone who filed the complaint or provided information about the matter.

5. Be prepared to document any information the Practitioner provides about the incident in question on the Preliminary Notification Form, which is to be completed as soon as the notification is provided.

6. Review and revise, as necessary, the general script for the conversation, which follows.

II. GENERAL SCRIPT FOR CONVERSATION WITH PRACTITIONER

1. Notify the Practitioner that a concern about professionalism has been raised and that the purpose of this conversation is to provide a **BRIEF PRELIMINARY** notification to the Practitioner, in accordance with the Professionalism Policy.

2. Inform the Practitioner that the matter is being reviewed and summarize how the review process works/next steps. *(See next two statements.)* Offer to provide the Practitioner with a copy of the Professionalism Policy.

3. Explain that if the report is determined to **NOT BE CREDIBLE**, the Practitioner will be informed and the review will be closed.

4. Explain that if the report is determined to be **CREDIBLE**, the Practitioner will be given details of the concern and asked to provide his or her perspective on the incident, prior to the Leadership Council taking any further action. However, the Practitioner is also free to submit input at any time, if the Practitioner would like to do so.

5. Remind the Practitioner to avoid any action that could be perceived as **RETALIATION**. This includes speaking with anyone who the Practitioner believes may have raised the concern or provided information about the matter, because even well-intentioned conversations can be perceived as intimidating.

6. Remind the Practitioner of the crucial importance of **CONFIDENTIALITY** to avoid waiving the protections offered by the state peer review protection law.

After the conversation, complete the Preliminary Notification Form that is set forth on the next page and include it in the Practitioner's Confidential File.

APPENDIX E *(cont.)*

CONFIDENTIAL PEER REVIEW DOCUMENT
PROFESSIONALISM ISSUE SUMMARY FORM

Name of Practitioner: _____

Date of incident under review (or range of dates): _____

Nature of Concern Raised	Summary of concern raised: _____ _____ _____
Initial Triage by Medical Staff Leader* and CMO/CQO	Initial determination (*indicate choice made*): ❑ ***Informal Resolution Appropriate*** *(minor concern and no pattern of conduct)* ❑ ***Additional Fact-*** triage ***Finding Necessary*** *(more significant issue or pattern)* Individuals making initial triage decision: _____
If Initial Triage Results in Informal Resolution of Minor Concern:	Date of ***Informal Resolution***: _____ Individual(s) conducting: _____ ❑ N/A
If Initial Triage Results in Determination to Conduct Initial Fact-Finding:	***Additional Fact-Finding***. Based on witness interviews and documentation review, the Medical Staff Leader and CMO/CQO determined as follows *(indicate choice made*): ❑ No further review necessary: ❑ Closed case, or ❑ Resolved informally with Practitioner ❑ Obtained Practitioner's response to concerns and then forwarded all information to Leadership Council for its review and resolution ❑ N/A
Leadership Council Determination and Action *(for cases referred to it)*	❑ No further review or action is required – close matter ❑ Educational Letter sent to Practitioner *(see attached letter)* ❑ Collegial Intervention conducted with Practitioner *(see attached letter)* ❑ Performance Improvement Plan for Conduct developed *(see attached letter)* ❑_Referred to MEC for review and action ❑ Referred to Employer for review and action ❑ N/A
MEC Determination and Action *(for cases referred to it)*	Summary of MEC determination and action: _____ _____ ❑ N/A
Employer Determination and Action *(for cases referred to it)*	Summary of Employer determination and action: _____ _____ ❑ N/A

*"Medical Staff Leader" means either the Medical Staff President or Department Chair.

APPENDIX F

INTERVIEW TOOL (SCRIPT AND QUESTIONS)

I. SCRIPT FOR INTRODUCTORY STATEMENTS

Instructions: Prior to the interview, the following information should be provided to each individual who is interviewed.

1. A concern about a Practitioner's behavior is being reviewed under the Hospital's Professionalism Policy. We would like to speak with you because you *[raised the concern]* **or** *[may have relevant information]*.

2. Any information you provide will be treated with the utmost confidentiality. It will not be shared with anyone outside the Hospital's peer review process. Also, Hospital policy states that your identity will generally not be disclosed to the Practitioner whose behavior is being reviewed except in extremely rare situations (for example, a Medical Staff hearing).

3. As part of our culture of safety and quality care, no retaliation is permitted against you for *[reporting this matter]* **or** *[providing information about this matter]*. This means that the Practitioner under review may not approach you to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe you have been retaliated against, please report immediately to your supervisor or any Medical Staff Leader.

4. The state peer review protection law requires the Hospital to maintain any information related to this review in a ***strictly confidential*** manner, so we may not be able to inform you of the outcome of the review. However, if you have any questions about this review process following the interview, please direct them to the President of the Medical Staff, Chief Medical Officer, WakeMed Medical Staff Officer and Senior Vice President of Quality or PPE Support Staff.

II. SAMPLE INTERVIEW QUESTIONS

Note: The following questions are intended to elicit basic information about an incident. These questions may be modified as appropriate, and should be supplemented with additional questions that specifically pertain to the incident being reviewed.

1. What was the date of the incident?

2. What time did the incident occur?

3. Where did the incident occur?

4. What is the name of the Practitioner who behaved inappropriately?

5. Who else was involved or witnessed the event? What are their titles and duties?

6. What happened? What did you see and hear?

7. Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?

8. Are there any notes or other documentation regarding the incident(s)?

9. Was a patient or a patient's family member directly or indirectly involved in the event? If so, name and medical record number.

10. Did you tell anyone about the incident?

    a. Whom did you tell?
    b. When and where did you tell them?
    c. What did you tell them?

11. How did you react to this incident at the time?

12. Did you experience or witness any retaliation or threatened retaliation by the Practitioner?

13. How do you think this incident affected patient care generally, Hospital operations, the work of your team, or your ability to do your job?

14. Have other incidents occurred, either before or after this incident? ***[If yes, repeat above questions for each incident.]***

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

16. Do you have any other information we should know about this matter? Please contact me if you recall or learn something new after we are finished talking.

APPENDIX G

COVER LETTER TO PRACTITIONER
ENCLOSING INFORMATION ABOUT REPORTED CONCERNS

VIA HAND DELIVERY

[Date]

[Name]
[Address]

Re: Information Related to Behavioral Concerns

Dear _____:

As you know from our conversation, concerns have been raised about your professional conduct at WakeMed _____ (the "Hospital"). As part of the review process, the Leadership Council would like you to be fully aware of the relevant issues and have an opportunity to respond to them. Accordingly, enclosed is information that summarizes the concerns that have been raised. *[Alternatively, the concerns could be summarized in this letter.]*

The Leadership Council would appreciate your perspective on these issues and any other information that you believe would be helpful to our review. Please provide your written response to me by _____ ***[date]***, so that it may be considered by the Leadership Council at its next meeting. *Optional: Specifically, please respond to the following questions:* _____ *[list specific questions, if any]*.

Your input into these issues is essential as we attempt to achieve our goal of having a timely, fair, and constructive review process. ***Please recognize that if you do not respond to this request for written input prior to the date set forth above, a process will commence (as set forth in the Professionalism Policy) that could result in the automatic relinquishment of your clinical privileges until the information is provided.*** We trust this will not occur, and look forward to your participation in the review.

Once the Leadership Council reviews your written input, it will decide whether it believes a meeting with you would be helpful to discuss this matter further. If so, we will contact you to arrange a meeting. If the Leadership Council believes a meeting is not necessary but you would nonetheless like to meet with the Council, you are welcome to meet with us at the next scheduled meeting of the Leadership Council.

The Leadership Council has an obligation to ensure that all peer review information (such as this letter) is maintained in a confidential manner. The Leadership Council also has an obligation to maintain a professional, non-threatening environment for all who work and practice at the Hospital.

Accordingly, as a courtesy, we wanted to remind you of the following obligations that apply to all Medical Staff members, as set forth in the Medical Staff Professionalism Policy:

(1) Like the Leadership Council, you must maintain all information related to this review in a ***strictly confidential*** manner, as required by North Carolina law. Specifically, you may not disclose this information to, or discuss it with, anyone ***except*** the following individuals without first obtaining the written permission of the Hospital: (i) the Leadership Council or its designees, or (ii) any legal counsel who may be advising you.

(2) You may not retaliate against anyone who you believe may have raised a concern about you, provided information regarding this matter, or otherwise been involved in the review process. ***This means that you may not, under any circumstances, discuss this matter with any such individual,*** because even well-intentioned conversations can be perceived as intimidating. ***Nor may you engage in any other retaliatory or abusive conduct*** such as confronting, ostracizing, or discriminating against such individual.

Please recognize that any retaliation by you, as described in the previous paragraph, is a very serious matter and will be grounds for referral for an independent review under the Medical Staff Professionalism Policy.

Thank you for your anticipated cooperation with our review process. We look forward to an expeditious and constructive resolution of this matter. Please don't hesitate to contact me if you have any questions.

Sincerely,

PPE Support Staff, Chief Medical Officer, WakeMed Medical Staff Officer and Senior Vice President of Quality or President of the Medical Staff

APPENDIX H

CONFIDENTIALITY AND NON-RETALIATION AGREEMENT

Concerns have been raised about my professional conduct at _____ Hospital (the "Hospital"). As part of the review process, the Leadership Council would like me to be fully aware of the concerns, as well as have the ability to provide my perspective and any response that I believe may be necessary or appropriate.

However, the Leadership Council also wants to take appropriate steps to maintain the confidentiality of the information under North Carolina and federal law, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, I agree to the following:

1. I will maintain all information that I review in a ***strictly confidential*** manner. Specifically, I will not disclose or discuss this information ***except*** to the following individuals: (i) my physician colleagues and/or Hospital employees who are directly involved in credentialing, privileging, and peer review activities concerning me, and/or (ii) any legal counsel who may be advising me. I will not share or discuss this information with any other individual without first obtaining the express written permission of the Leadership Council or Chief Medical Officer.

2. I understand that this information is being provided to me as part of the Medical Staff's and Hospital's policy of attempting to utilize collegial intervention and progressive steps, where possible, to address any questions or concerns that may arise with my practice. In addition to discussing these matters directly with the Medical Staff and Hospital leadership, I understand that I may also prepare a written response and that this response will be maintained in my file.

3. I understand that the Hospital and the Medical Staff have a responsibility to provide a safe, non-threatening workplace for my physician colleagues and for Hospital employees. I therefore agree that:

   (a) ***I will <u>not discuss</u> the information that I review from my file with any individual who I believe may have provided the information*** because even well-intentioned conversations with such individuals can be perceived as intimidating. ***Accordingly, I understand that any such discussions will be viewed as retaliation and a violation of the Medical Staff Professionalism Policy.***

   (b) ***I will <u>not engage</u> in any other retaliatory or abusive conduct with respect to these individuals.*** This means that I will not confront, ostracize, discriminate against, or otherwise mistreat any such individual with respect to any information that the individual may have provided.

4. I understand that any retaliation by me, as described in the previous paragraph, is a very serious matter, constitutes unprofessional conduct, and cannot be tolerated. Any such conduct by me will represent independent grounds for review pursuant to the Medical Staff Professionalism Policy.

By signing this Agreement, I understand that I am ***not waiving*** any of the rights or privileges afforded me under the Medical Staff Bylaws and related documents. I remain free to raise legitimate concerns regarding the care being provided, or the conduct being exhibited, by a nurse or other Hospital employee, another physician, or the Hospital itself. ***However, like everyone else, I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.*** These channels are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff or Hospital leadership to fully review and assess the matter and take action to address the issue, as may be necessary.

_____ _____

, M.D./D.O. Date

Note: After this agreement is signed, a copy shall be returned to the Practitioner for reference.

APPENDIX I

PERFORMANCE IMPROVEMENT PLAN OPTIONS FOR CONDUCT

IMPLEMENTATION ISSUES CHECKLIST
(For use by the Leadership Council and Medical Executive Committee)

TABLE OF CONTENTS

PAGE

Note: The Implementation Issues Checklists in this Appendix may be used by the Leadership Council and Medical Executive Committee in developing and monitoring Performance Improvement Plans ("PIPs"). Checklists may be used individually or in combination with one another, depending on the nature of the PIP.

A copy of a completed Checklist may be provided to the Practitioner who is subject to the PIP, so that the Leadership Council/Medical Executive Committee and the Practitioner have a shared and clear understanding of the elements of the PIP. While Checklists may serve as helpful guidance, there is no requirement that they be used. Failure to use a Checklist or to answer one or more questions on a Checklist will not affect the validity of a PIP.

PIP OPTION	IMPLEMENTATION ISSUES
Meeting with Designated Group	***Who Should Meet with Practitioner?*** ❑ Medical Staff committee: _____ ❑ Other designated ad hoc group (may include Board Chair or other Board members), including: _____ ❑ May Practitioner bring a colleague (<u>not</u> legal counsel) to the meeting? ❑ Yes ❑ No Is pre-meeting to plan intervention necessary? ❑ Yes ❑ No If yes, where and when: _____ _____ ***Scheduling Meeting with Practitioner*** ❑ Date of meeting: _____ ❑ Time of meeting: _____ ❑ Location of meeting: _____ ***Notice of Meeting*** ❑ Notice of meeting sent by: ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ WakeMed Medical Staff Officer and Senior Vice President of Quality ❑ Hospital CEO ❑ Other: _____ ❑ Practitioner notified that this is a peer review meeting with colleagues, therefore: ❑ No attorneys allowed at the meeting ❑ No audio or video recording of meeting ❑ Does notice state that failure to appear results in automatic relinquishment of clinical privileges? ❑ Yes ❑ No ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Documentation*** ❑ If not already provided, will documentation/substance of reports regarding inappropriate conduct be shared before or during meeting? ❑ Yes ❑ No ❑ If yes, has Practitioner been provided a cover letter or agreement explaining his/her obligation to maintain the confidentiality of the information and not to retaliate against any individual who may have reported? ❑ Yes ❑ No ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
Behavior Modification Course	***Scope of Behavior Modification Course*** ❑ Acceptable programs include: _____ _____ ❑ Leadership Council or Medical Executive Committee approval required before Practitioner enrolls: ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the behavior modification course? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination _____ ❑ Time Frame ❑ Practitioner must enroll by: _____ Date ❑ Program must be completed by: _____ Date ***Practitioner's Responsibilities*** ❑ Sign release allowing Leadership Council or Medical Executive Committee to provide information to the behavior modification course (if necessary) and course to provide report to Leadership Council or Medical Executive Committee _____ _____ ❑ Practitioner must submit ❑ Documentation of successful completion signed by course director ❑ Other: _____ _____ ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)***	***Drafting/Contents of Personal Code of Conduct*** ❑ Who will draft the Personal Code of Conduct? ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ WakeMed Medical Staff Officer and Senior Vice President of Quality ❑ Hospital CEO ❑ Legal Counsel ❑ Other: _____ ❑ Practitioner informed that he/she may provide response for inclusion in file. ❑ Copy of personal code of conduct included in Practitioner's credentials/ quality file. ❑ Is Practitioner required to agree in writing to abide by the personal code of conduct? ❑ Yes ❑ No If yes, written agreement to abide by personal code of conduct received on: _____ Date ❑ Does the personal code of conduct describe the following consequences of a confirmed violation? ❑ Yes ❑ No ***Consequence of first violation (e.g., final warning):*** _____ _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date ***Consequence of second violation (e.g., short-term suspension):*** _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date

PIP OPTION	IMPLEMENTATION ISSUES
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)*** ***(cont'd.)***	***Consequence of third violation (e.g., recommendation for disciplinary action, perhaps limited hearing):*** _____ _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date ***Review/Signature*** ❑ Who must review and approve the letter outlining the personal code of conduct? ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ WakeMed Medical Staff Officer and Senior Vice President of Quality ❑ Full Leadership Council ❑ MEC ❑ Other Individuals: _____ ❑ Who signs/sends the letter outlining the personal code of conduct? ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ WakeMed Medical Staff Officer and Senior Vice President of Quality ❑ Hospital CEO ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
"Other" ***Wide latitude to utilize other ideas as part of PIP, tailored to specific concerns*** ***Examples:*** • ***Practitioner must have a chaperone;*** • ***Practitioner must attend CME for communication issues;*** • ***Practitioner must study and present grand rounds on behavior/ patient safety connection;*** • ***Practitioner required to apologize in writing (letter must be approved before it is sent) or in person accompanied by appropriate Medical Staff leader.***	