INOVÁ LOUDOUN HOSPITAL  
MEDICAL STAFF POLICY & PROCEDURE 

TITLE: Citizenship Policy 

POLICY STATEMENT 

This policy applies to all practitioners at Inova Loudoun Hospital including all Medical Staff members who are employed by ILH. 

It is the policy of Inova Loudoun Hospital that all individuals within its facilities be treated with courtesy, respect, and dignity. To that end, the Medical Staff requires that all practitioners conduct themselves in a professional and cooperative manner in the hospital. 

OBJECTIVE 

The objective of this policy is to ensure optimum patient care by promoting a safe, efficient, cooperative and professional health care environment. 

This policy is by definition subordinate to the Bylaws, which specifically require that Medical Staff members refer to actions that are “disruptive to the operations of the Hospital or the Medical Staff” as grounds for a formal complaint. The present document/policy is written in recognition of the fact that, under most circumstances, when a specific complaint is received and investigated, the isolated incident in question may not be seen as sufficiently severe and/or disruptive enough to justify action under the Bylaws. However, well-documented complaints of the same type of behavior occurring repeatedly may lead to the conclusion that such disruption is in fact taking place, and this policy provides a framework for documentation of such a pattern. More importantly, it provides a structure of less severe graduated responses that are intended to promote behavior change beneficial both to Hospital operations and to the individual practitioner in question. 

The Bylaws include under Basic responsibilities of staff membership that members “abide by the Medical Staff Bylaws and Rules and Regulations and by all other lawful standards, policies and rules of the Hospital.” That standard applies to this policy, the acceptance of this policy, and the processes defined herein shall be required off all members on initial application and at renewal of membership. 

DEFINITIONS 

Disruptive conduct is generally defined as conduct that interferes with the operation of the Hospital, affects the ability of Hospital personnel or other practitioners to perform their assigned duties competently, or adversely affects the community’s confidence in the Hospital’s ability to provide quality patient care. Although behavior resulting from a deficit of professional knowledge or skill may be viewed as disruptive by the above definition, such behavior is addressed by the Bylaws and Peer Review Policy and is not covered within the scope of this policy. 

Disruptive conduct by a practitioner includes, but is not necessarily limited to the following actions toward colleagues, hospital personnel, patients, or visitors: 

- Hostile, angry or aggressive confrontational voice or body language 
- Attacks (verbal or physical) that are reasonably perceived to go beyond the bounds of fair professional conduct; 
- Physical expressions of anger such as destruction of property or throwing items; 
- Abusive language or criticism directed at the recipient in such a way as to ridicule, humiliate, intimidate, undermine confidence, or belittle; 
- Criticism of caregiver in front of a patient or patient’s family;
• Writing of inappropriate, critical or litigious comments/notes in the medical record;
• Unwelcome sexual advances, requests for sexual favors and other inappropriate sexually oriented behavior.
• Discrimination on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation.

Although most disruptive conduct reports will result from behavior observed on Hospital premises, telephone behavior and electronic communications meeting one of the above criteria are also subject to valid complaint under this policy.

Citizenship refers to the quality of personal interactions with other caregivers in the hospital environment. In this policy, the term in no way refers to the nationality or immigration status of any individual.

STRUCTURE OF AUTHORITY

In addition to the Medical Staff leadership structure defined in the Bylaws, there shall be a Citizenship Committee appointed by the Chief of Staff, which shall be considered one of the committees performing the “Patient Care Audit and Monitoring Function” defined in the Bylaws. It will consist of three to five members of the active or emeritus Medical Staff, who are not employed by the Hospital and have at least 10 years of staff membership. Any individual actively practicing in direct competition with a practitioner being reviewed under this policy shall be recused from committee meetings considering that practitioner’s case.

All members of this committee must agree to maintain confidentiality regarding any complaints, the identity of any identified practitioner, and the outcome of any process undertaken under this policy. In addition to the duties assigned to the committee under this policy, other duties devolving from other policies governing physician behavior may be assigned to it by the Chief of Staff.

PROCEDURE

1. For review under this policy, any disruptive behavior or conduct by a practitioner must be documented in written form. The individual reporting the incident may make use of computer software, such as Quantros, provided by the Hospital for the recording and reporting of adverse events. Alternatively, the individual may file a written report about the incident with the administrator/supervisor of his/her department or functional unit containing:
   a) The date, time and location of the behavior in question and names of involved persons
   b) A factual description of the incident, the circumstances surrounding the incident, and the behavior in question
   c) The name(s) of any patient or family member(s) involved in the incident, or any other individual who was a witness to the incident
   d) The consequences, if any, of the disruptive behavior as it relates to patient care, personnel or hospital operations; and
   e) A description of any action taken to intervene in, or remedy the incident

2. Any written report will be signed and dated by the individual receiving the report and by the individual making the report. Such reports and any computer reports indicating disruptive behavior will be forwarded to the Medical Staff Office, which will proceed as follows:
   a) After confirming that the report in fact concerns behavior by a practitioner covered under this policy (hereby referred to as “the practitioner), the Medical Staff Office shall refer the report to the practitioner’s department chairman, or authorized substitute if the chairman is unavailable, or to the Chief of Staff if the report concerns the chairman or a member of the chairman’s practice group.
b) The officer receiving the report will review the appropriate confidential peer review file to determine if there have been prior reports of disruptive behavior, and will review the records and the current report for any indication of impairment as defined in the Hospital’s Impairment Policy.

i) If there is evidence of impairment, the officer may refer the case for review and possible action under the Impairment Policy; however, resolution of any impairment as defined under that policy will not preclude further review of future reported behavioral incidents under this policy.

ii) If there is no evidence of impairment and no other reports were filed concerning the practitioner’s behavior subsequent to the adoption of this policy, the officer will proceed with collegial intervention as described in #3 below.

iii) If there are other reports regarding the practitioner’s behavior filed since the adoption of this policy, the officer will refer the case to the Citizenship Committee, which will proceed according to #4 below.

3. The officer proceeding with collegial intervention shall contact the practitioner and request a meeting; a department chairman may request the presence of one other individual, either the Chief of Staff or a representative from Administration, for the meeting. Reasonable effort will be given to accommodate the practitioner’s schedule, but the practitioner shall be informed that failure to schedule or attend such a meeting will result in referral for corrective action under the Bylaws.

At the initial meeting, the practitioner will be informed that a concern was expressed regarding his/her behavior or conduct. The practitioner shall be advised of the nature of the incident and shall be given the opportunity to respond. The practitioner shall also be advised that, if the incident occurred as reported, and if there are no clear mitigating circumstances, his/her conduct or behavior was inappropriate and inconsistent with the standards of the Hospital. In such case:

a) The practitioner will be informed of the terms of this policy, and the process that would occur if future incidents are reported.

b) And

i) The practitioner will be offered the option of a voluntary mental health evaluation with a practitioner of his/her own choosing, and without activation of the Impairment Policy, with the understanding that more aggressive intervention under this policy or the Impairment Policy may be taken if future incidents occur.

ii) Or, if on the basis of the interview the officer concludes that there is in fact evidence of impairment, the officer will refer the case for review and possible action under the Impairment Policy.

The officer will submit a report of the meeting to be place in the practitioner’s peer review file. Further action is not required if no further incidents occur.

4. On receipt of any referral made under this policy the Citizenship Committee shall follow this procedure:

a) It will inform the individual who filed the report that a review is being conducted and that appropriate action will be taken. The Chair shall extend the medical staff’s appreciation to the individual referring the concern, but will inform the individual that any conclusions or findings under this process will be kept confidential.

b) It will schedule a meeting with the practitioner. Reasonable effort will be given to accommodate the practitioner’s schedule, but the practitioner shall be informed that failure to schedule or attend such a meeting will result in referral for corrective action under the Bylaws. The practitioner shall also be informed that the meeting is intended to be informal and collegial. However, the practitioner will
also be informed that any retaliation against any person involved in the incident or reporting process shall constitute grounds for immediate referral to the Chief of Staff for corrective action under the Bylaws.

c) Prior to meeting with the practitioner, the committee shall review all available incident documentation.

d) At the scheduled meeting, the committee shall review the content of the reports, and shall provide the practitioner an oral narrative of the events in question as documented. The practitioner shall be afforded the opportunity to provide an alternative narrative in oral and/or written form.

e) The committee may elect to resolve the issue immediately, or excuse the practitioner for further discussion and review, in which case it may inform the practitioner of its conclusions either with another meeting or in writing.

f) Regardless of the number of prior reports on file for the practitioner, the committee shall always have the following options:

i) To decide that there is no evidence that an incident of disruptive behavior took place and so report in writing to the Chief of Staff. In such case, the incident in question will not be kept in the practitioner’s peer review file, but this will not affect any reports of prior incidents.

ii) Decide that there is evidence of impairment and invoke the Impairment Policy for appropriate evaluation, including mental health evaluation, or for action prescribed under that policy. However, if there has been a prior referral for impairment and the committee determines that disruptive behavior is continuing in spite of intervention under that policy, the committee may take stronger action under this policy, and prior disruptions shall not be excluded from consideration solely on the basis of current or prior reported impairment.

iii) Decide that sufficient evidence is present for direct referral for corrective action under the Bylaws.

g) In addition, the committee shall have the following options or requirements for action based on the number of prior reports:

i) If evidence is presented of a second disruptive behavior incident, informal counseling may be offered. In such case, the committee will meet further with the practitioner and advise regarding methods for avoidance of further such incidents. Referral to an anger management class or program will be encouraged when appropriate. The committee shall submit a report for the practitioner’s peer review file.

ii) If evidence is presented of a third disruptive behavior incident, the committee must demand behavior from the practitioner conveying adequate evidence of genuine commitment to reformed behavior. A leave of absence of at least 2 weeks, applicable to the Hospital and to any other Inova Hospitals and Inova-owned facilities may be accepted under this circumstance. A written document from the practitioner expressing genuine regret and outlining positive steps for reform of behavior may be accepted alternatively.

iii) If evidence is presented of a fourth disruptive behavior incident, the practitioner will be given the choice of leave of absence of at least 4 weeks, applicable to the Hospital and to any other Inova Hospitals and Inova-owned facilities, or referral for corrective action under the Bylaws.
iv) Any further confirmed disruptive behavior incidents must be referred for corrective action under the Bylaws.

h) At the conclusion of the process outlined under this policy regarding any specific incident, the committee shall prepare a report including a narration of the incident, the process followed and its conclusions. If the committee concluded that no disruptive incident took place, it shall forward this report to the Chief of Staff but the report will not be placed in the practitioner’s peer review file. For any other action other than referral for corrective action, the report will be placed in the practitioner’s peer review file. If there is a referral for corrective action, the report and any prior reports shall serve as evidence for further review of the practitioner’s case under the process defined in the Bylaws.