

ARTICLE XV

GENERAL RULES REGARDING PRACTICE IN THE HOSPITAL

15.1 Behavioral Code of Conduct

Appropriate conduct in the workplace is critical to patient safety and quality of care. Atrium Medical Center and the Medical Staff recognize that our interactions with each other and our patients serve as a reflection of our values and standards, and directly impact patient safety, quality, and satisfaction. Each patient, family member, guest, employee, volunteer, and all members of the healthcare team have the equal right to expect Respect, Integrity, Compassion, and Excellence, as the core values embraced by the Hospital and Health System and aligned with the Hospital and Health System guiding principles to

- respect each person's dignity;
- put the patient and his/her family at the center of care;
- build trust at every opportunity;
- intentionally manage patient and family perceptions;
- act with integrity to do the right thing in all aspects of our responsibilities;
- understand that patient experience starts with me – every person, every time;
- live up to our core values in every encounter;
- serve with compassion that embraces each individual's concerns and hopes;
- care for and care about the patient and their family as the first members of the care team;
- commit to excellence as measured to the highest level of performance - safety and quality are expected;
- provide a seamless experience, every person, every time, in every way;
- do the critical few things exceptionally well; and
- build a team culture that fosters collaboration and resilience.

It is the expectation of the medical staff organization to commit to conduct that has a positive influence on those we serve and toward that end, generally define acceptable and unacceptable behaviors and have established processes which are of a progressive nature for addressing unacceptable behaviors through the Medical Staff Governing Documents.

Behaviors that are not in alignment with the guidelines as outlined below are considered unacceptable. Acceptable behavior guidelines, include, but are not limited to the following:

- Patients will be informed about their care. Patient rights and reasonable requests from patients, their families and visitors are to be promptly evaluated and acted upon appropriately.
- Appropriate mutually respectful behavior is expected at all times. Providing reasonable explanations for delays is acceptable. Derogatory comments are not.

- Praise in public and constructively criticize in private. Issues will be discussed in the appropriate settings respectful of all parties. Condescending, derogatory, demeaning criticism, and personal attacks are unacceptable.
- Appropriate communication (written, verbal, or non-verbal) is expected at all times. Unacceptable communication behaviors include, but are not limited to, communications that disrupt the delivery of care. Recognition of different communication styles should be considered as we look for ways to effectively communicate with others. Furthermore, criticism or personal attacks against physicians, practitioners, dentists, hospital personnel or the hospital staff itself shall not appear in the medical record.
- Questions posted by patients, students or staff that ensure understanding, facilitate learning, and contribute to the overall safe delivery of quality patient care are to be answered respectfully.
- Colleagues and those we serve who differ by gender, race, age, religion, culture, national origin, mental and physical abilities, sexual orientation, etc. are to be treated with dignity, respect and compassion.
- Professional behavior is to be expected at all times.
- Retaliation against any member of the health care team who has reported an instance of violation of the organization's established Code of Conduct or who has participated in the investigation of such an incident, regardless of the perceived veracity of the report if done so in good faith is unacceptable. "Good faith" is defined as an honest belief without hostility that an act or acts are in violation of the Code of Conduct.

Violations of this Code of Conduct by Medical Staff members shall be addressed exclusively through the Medical Staff process, shall be reported to the Medical Staff President and/or department/section chair, and shall be addressed in accordance with the rights and responsibilities as outlined in the Atrium Medical Center Medical Staff Governing Documents (e.g. Medical Staff Bylaws, Rules and Regulations, and Related Manuals).

15.2 Reports

It shall be the responsibility of each Medical Staff Appointee to report to the appropriate Section Head or Department Chair, or, in his absence, to the President of the Medical Staff any conduct, acts or omissions by Medical Staff Appointees of which he is aware which he, in good conscience, believes to be detrimental to the health or safety of patients or to the proper functioning of the Hospital, or which violate professional ethics.

15.3 Confrontation Between Physician and Employee of Hospital

Any dispute between a nurse, Hospital employee or administrator and a Practitioner, involving a matter of medical judgment, shall be referred to the appropriate Department Chair or the President of the Medical Staff.

15.4 Disaster Plan

Atrium Medical Center is required to perform at least two (2) Emergency Management Drills per year (unless actual Emergency Management events occur which count in lieu of a drill). Each Medical Staff Appointee shall be responsible for familiarizing himself with the plan and are encouraged to participate in scheduled Emergency Management Drills. The President of the Medical Staff and/or the Chief Medical Officer of the Hospital (or other section chairs as appropriate) may be assigned to the Medical Care Branch Director position (as outlined in the Hospital Incident Command System [HICS]). During all Emergency events, the Medical Care Branch Director will work with the Incident Commander to coordinate activities and give directions affecting medical care. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, all medical staff will follow Code Evac procedures as outlined in Atrium Medical Center's Emergency Management Manual.

15.5 On-Call Notification Procedure

When neither the first nor the second on-call Practitioner for a Section or Department responds to an Emergency Room call, the appropriate Department Chair should be contacted. If the above are unavailable, the President of the Medical Staff should be contacted.

15.6 Dues

All persons appointed to the Medical Staff shall pay annual Medical Staff dues in an amount recommended by the MEC and approved by the Board. Failure to pay annual dues shall result in automatic relinquishment of Medical Staff appointment and clinical privileges. Two billings shall be rendered if necessary, followed by a certified letter, requesting payment and stating the consequences of nonpayment. Any Medical Staff Appointee whose dues have not been received thirty (30) days after the date of receipt of the certified letter shall be deemed to have automatically relinquished his Medical Staff appointment and clinical privileges and shall be so informed in writing.

15.7 Advertising and Media Relations

Medical Staff Appointees shall conform to standards on advertising and media relations as adopted by the American Medical Association. Advertising and publicity should be designed to inform and educate the public in a direct, dignified, and readily comprehensible manner. Such communications shall not be misleading because of the omission of necessary material, shall not contain any false or misleading statement, or should not otherwise operate to deceive.

15.8 Adoption and Amendment Rules & Regulations

The MEC shall have the initial responsibility to formulate and adopt Rules and Regulations. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the Hospital's current emphasis with respect to Medical Staff organization and function and the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the community. If significant changes are made in the Rules and Regulations, Medical Staff Appointees and other individuals who have delineated Clinical Privileges will be provided with a revised text of the written materials.

Medical Staff Rules and Regulations may be adopted, amended, or repealed by the following action:

- (a) Proposed additions, amendments or repeals shall be presented to the Medical Executive Committee. An affirmative vote shall be a simple majority of the quorum.
- (b) If an affirmative vote is obtained in the Medical Executive Committee, the proposed changes will be presented to the Board for approval.

15.9 Medical Students/Physician Assistant Students

All medical students/physician assistant students participating in a training program, approved by their medical school, at the Hospital must be assigned to a specific Practitioner or medical staff department.

The student must complete a registration form and confidentiality statement available in the Medical Staff Office on or before the first day of training. Registration information is to include: full name and address, birth date, medical school affiliation, sponsoring Practitioner or medical staff department, and expected dates of training.

The individual practitioner or respective Department is responsible for the conduct and training experience of the student. The practitioner or the Department members must personally supervise all training experiences including all procedures. All concerns regarding the experiences or procedures performed shall be directed to the sponsoring Practitioner or Medical Staff Department Chair. Disagreements or questions will be decided in consultation with the President of the Hospital, Department Chair and/or President of the Medical Staff.

Students must provide the Medical Staff Office with a copy of their behavioral objectives for the rotation. A copy of the objectives and registration form will be sent to the following: Medical Records Director, Quality Management Director and Vice President of Patient Care Services.

15.10 Residents/Fellows

All medical or surgical residents/fellows participating at the Hospital in an accredited or approved training program approved by their teaching institution must be assigned to a specific Practitioner.

The resident/fellow must complete a registration form and confidentiality statement available through the Medical Staff Office before the first day of training. Registration information is to include: full name and address, birth date, name of teaching institution, program director's name, sponsoring Practitioner(s), expected dates of training, and medical school attended.

The sponsoring Practitioner(s) is responsible for the conduct and training experience of the resident/fellow. The Practitioner(s) must supervise all training experiences including all procedures and documentation in the chart. Any concerns regarding the experiences or procedures performed shall be directed to the sponsoring Practitioner(s) or Medical Staff Department Chair and resolved if necessary in consultation with the President of the Hospital, Department Chair and/or President of the Medical Staff.

Residents/fellows must provide the Medical Staff Office with a copy of their current Ohio medical license or training certificate and a malpractice insurance binder.

15.11 Annual Influenza Vaccination

All Appointees to the Medical Staff and Allied Health Professional Staff shall be required to submit to the Medical Staff Office evidence of annual influenza vaccination, or documentation from a licensed physician indicating an evidence-based medical contraindication against influenza vaccination. The allotted time period will coincide with the Hospital's annual employee influenza vaccination program cycle, which usually occurs in the last four months of the calendar year.

In order to receive an exemption, a declination/exemption form must be completed by the Appointee and documentation from a licensed physician indicating an evidence-based medical contraindication against influenza vaccination must be provided. Once an exemption is approved by the appropriate department chair, the Medical Staff/Allied Health Professional staff Appointee shall not be required to obtain the exemption annually.

Failure to comply with the annual vaccination requirement by the end date of the Hospital's vaccination program cycle shall be deemed a voluntary temporary loss of clinical privileges until compliance has been verified. A temporary loss of clinical privileges lasting greater than thirty (30) days shall be deemed a voluntary resignation of current appointment status and/or clinical privileges without recourse to the procedural rights set forth in the Medical Staff Bylaws.

Should this occur, the Appointee will be notified of voluntary resignation status and required to pay a monetary fine of \$100 along with submission of evidence of immunization and/or approved exemption within thirty (30) days of voluntary resignation in order to reinstate current appointment status and/or clinical privileges. If voluntary resignation status exceeds thirty (30) days, practitioner will be subject to application processing and fees outlined in the Credentials Manual, along with submission of evidence of immunization and/or approved exemption.

Initial applicants to the Medical or Allied Health Professional staff scheduled to start between October and March shall be required to submit evidence of influenza vaccination, or have received exemption approval, prior to clinical privileges effective date. Initial applicants to the Medical or Allied Health Professional staff whose clinical privilege effective date falls between April and September shall be required to comply with the annual influenza vaccination program cycle requirements outlined above.

Telemedicine providers are exempt from Section 15.11 requirements, as these practitioners provide services from a distant-site facility.

15.12 Medical Staff and Nursing Communication Channels:
(Reference Nursing Policy and Procedure #182.00)

The appropriate "chain of command" for administrative and medical staff notification when patient care issues present and problem-solving is needed to establish guidelines for communication. Examples of such circumstances may be things like questioning of medical orders or obtaining alternate coverage for in-patient emergency situations. This establishes general communication channels, and judgment should be used depending on the severity and complexity of the situation.

A "chain of command" along Medical Staff and Nursing Administrative lines should be followed when communications are necessary to resolve patient care issues and problems.

Levels of the Medical Staff chain of communication generally correspond to various levels on the Nursing/Administrative chain of communication. Involvement should be obtained at each level before proceeding to the next level in most circumstances.

(a) Medical Staff Chain of Communication

- (1) The Resource Nurse or Clinical Coordinator will address a concern with the Attending physician or if unavailable, the covering physician. Failing this
- (2) The Resource Nurse or Clinical Coordinator will notify the nurse manager or Administrative Clinical Coordinator prior to calling the Unit Medical Director (if applicable). Failing this:

- (3) The Manager or Administrative Clinical Coordinator will for immediate, life-threatening emergency situations, call Code Blue; for non-immediate emergency situations, call the Practitioner on emergency call for the departments or specialty area of patients. Failing this:
- (4) The Manager or Administrative Clinical Coordinator will notify the Vice President of Patient Care Services prior to calling the Chair of the appropriate Medical Staff Department. Failing this:
- (5) The Vice President of Patient Care Services will notify the Administrator-On-Call prior to calling the President of the Medical Staff.

Adopted by the Medical Staff on 10/17/90

Approved by the Board of Trustees on 12/13/90

Addition of Section 15.9 approved by the Board of Trustees on 12/19/91

Addition of Section 15.10 approved by the Board of Trustees on 1/28/93

Addition of Section 15.8 (g) approved by the Board of Trustees on 4/22/93

Revisions to Sections 15.2, 15.4, 15.7(b), 15.9, 15.11(a)(4&5) and the addition of Section 15.10 approved by the Board of Trustees on 10/18/96

Revisions to Article 15 adopted by the Medical Staff on 9/30/99

Approved by the Board of Trustees on 10/28/99

Revisions to Sections 15.9 and 15.10 approved by the MEC 4/2/02

Approved by the Board of Trustees on 4/25/02

Revision to Section 15.3 and deletion of 15.8 approved MEC 8/2011 and Board 8/2011

Addition of Section 15.11 bylaws cmte 8/17/12; MEC recommendation 9/11/12; Board approval; 9/2012; medical staff vote 11/2012

Addition of Section 15.1 approved by MEC 1/8/13

Approved by AMC Board approval 2/20/13