

<b>This policy applies to:</b> <input checked="" type="checkbox"/> <i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> February 2010
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## I. PURPOSE

The SHC Medical Staff has a statutory responsibility for the quality of care delivered to our patients. The primary responsibility for this resides with the Medical Executive Committee (MEC), Care Improvement Committee and the Quality Improvement and Patient Safety Committee.

Professional behavior is increasingly recognized as an essential component of high quality medical care. Inappropriate and disruptive behavior, along with less egregious failures to achieve the highest levels of professionalism in interactions with patients, families and co-workers, can have a serious impact on the delivery of optimal medical care. Such behavior violates the precepts of a Fair and Just Culture, has a corrosive and intimidating effect on co-workers, reduces employee satisfaction, and can also seriously impair the communication that is vital to our goal of delivering the highest levels of safety and quality in health care.

In recognition of the vital importance of professional behavior to our institutional mission, and in recognition of the difficult nature of dealing with issues of professional behavior, the Medical Staff has established this Committee on Professionalism (the “Committee”), as an a sub-committee of the Medical Executive Committee

The purpose of the Committee is to serve as a focus of expertise and as a resource for monitoring and improving the professional behavior of our Medical Staff, both individually and collectively. It is hoped that the Committee on Professionalism members will develop a level of expertise and of respect from their peers such that the institutional response to disruptive behavior will be better informed, better received, more timely and more effective.

## II. MEMBERSHIP

The members of the Committee will be appointed by the Chief of Staff. The members will, to the extent practicable, reflect the diversity of the Medical Staff with regard to specialty, mode of practice (community v. full time faculty), gender, ethnicity, etc. The majority of members will be active clinicians who are highly respected by their peers. Membership will include the Chief of Staff, Vice

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Chief of Staff, Immediate Past Chief of Staff, Chief Medical Officer, and Chief Nursing Officer (or designee).

### **III. PARS PROGRAM**

One indicator of a quality problem can be practices of physicians and other Licensed Independent Practitioners that result in an unusually large number of complaints from patients and families. The Committee will use the patient complaint methodology developed at Vanderbilt University Medical Center, known as the Patient Advocacy Reporting System (PARS®), along with a series of structured interventions developed there and used at many medical centers. (See references)

#### **A. Screening:**

1. All SHC physicians will be assessed using this methodology, using the data currently available through the Office of Guest Services patient complaint system. In addition, special attention will be paid to new members of the Medical Staff, who will be assessed closely for a period of 12-18 months after appointment.
2. SHC physicians assessed by the PARS methodology, whose complaints by number and nature appear to warrant review, shall be referred to the Committee, whose Chair will review the file. If the Chair agrees that further review is indicated, he/she will select an appropriate messenger from the Committee. If the physician is a Service Chief, or similarly highly placed leader, the Chief of Staff may be the messenger. The messenger will also review the file, and together with the Chair shall make a final determination as to whether intervention is indicated. Disagreement will be resolved by involvement of another messenger from the Committee.

#### **B. Level I Intervention:**

1. If intervention is considered indicated, the Medical Staff member in question shall receive a visit from a trained SHC physician messenger who will communicate to the physician the patient

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complaint data and the methodology that documents his/her risk profile. The messenger should generally not be the Service Chief nor other physicians who do, or may in the future, play a supervisory or disciplinary role for this Medical Staff member.

2. The nature of the Level I intervention visit is described in the PARS program literature (See references). The member will be given information at that visit regarding available resources to assist in remedying communications difficulties and other problems with professional behavior. The Wellbeing Committee is always available to the member at any stage of the process, should the member choose to request its assistance.
3. Knowledge of Level I interventions will be limited to only the member, the messenger and the Chair of the Committee. The individual's Service Chief will not be informed about this initial visit except when the complaint suggests grossly inappropriate physician behavior or behavior that may endanger the health and safety of patients or others, or if the Committee otherwise determines that the Service Chief should be informed. The messenger will report back with a general assessment of the visit to the Committee without including the physician's name.

C. Level II Intervention:

1. Following this initial messenger visit, the physician risk profile will generally be monitored for up to 12 months. If, at the end of that time, improvement has been judged to be satisfactory as evidenced by significant reduction in complaints and other relevant factors, the physician will resume the regular rate of monitoring of all Medical Staff members. However, if the patient complaint status does not improve, a second intervention with the physician will be carried out.
2. A Level II Intervention is tailored to the extent and severity of the problem, but will in all cases include a second messenger visit. In addition, at this point the situation will be discussed with the Service Chief. If the physician is a community physician, the Deputy Service Chief will be included in this discussion. All such

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physicians will be counseled by both the messenger and the Service Chief, and depending on the nature of the complaints may choose, or be required, to do one or more of the following:

- Take a course in risk management
- Take a course in improving communication skills
- Other similar measures, as deemed appropriate
- The Wellbeing Committee is available to the member, should the member choose to request their assistance.

D. Level III Intervention:

1. Following a Level II Intervention, the Committee will continue to monitor patient/family complaint data. Regular updates, at least every six months, will be provided to the Service Chief. If improvement occurs during the next 12 months, the physician can resume the regular monitoring program. However, if significant improvement has not occurred, a Level III Intervention will be initiated. This will be the responsibility of the Service Chief in consultation with the Chief of Staff, the Committee, and others as indicated. Options include:

- Further remedial measures as described under Level II Intervention.
- Continued counseling and follow up by the Service Chief and/or Deputy Service Chief
- Initiation of Informal Counseling or Corrective Action pursuant to the Medical Staff By-Laws as warranted.
- The Wellbeing Committee is available to the member, should the member choose to request their assistance.

#### IV. COMPLAINTS FROM OTHER SOURCES

A. Screening

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Other sources of information about Medical Staff members' professional behavior include our current incident reporting system (the Patient Safety Net), other reporting systems and direct individual reports. These reports may also raise concerns about quality of care and may require intervention.

**B. Initial Response**

These complaints will be initially handled by the Chief of Staff and a number of designees (see the Medical Staff Code of Professional Behavior Policy for additional procedural detail and a list of designees). When the Chief of Staff (or designee) desire advice as to how best to address professional behavior issues with one or more Medical Staff members, the Committee may serve as a forum for discussion.

**C. Escalation**

When a serious individual incident, or a series of lesser incidents, is thought by the Chief of Staff (or designee) to require more substantial intervention than an individual discussion with the individual member in question, referral to the Committee is indicated. The Committee will then provide advice as to next steps.

**D. Meeting With the Committee**

Medical Staff members who are referred to the Committee may be asked to meet with the Committee (or a smaller sub-committee) to discuss the questions raised about their behavior. Prior to this meeting, the member will be provided with all complaints available to the Committee (redacted if necessary to protect identity of anonymous complainants) and given an opportunity to submit a written response.

**E. Consequences**

Following a meeting with a Medical Staff member, the Committee may decide to implement a Level II intervention (as described above), or in more egregious instances may recommend a Level III intervention (described above) or even recommend a summary suspension to the Chief of Staff (as outlined in the Medical Staff Bylaws).

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**V. SYSTEM ISSUES**

The Committee will be vigilant in identifying ways in which our systems of care may fail to facilitate the highest standards of professional behavior. While systems challenges can never excuse disruptive behavior, it is important that we continually strive to create a culture and an environment which do not unduly strain individual members' capacities for professionalism.

When individual cases reveal systems issues which may have contributed to inappropriate behavior, these issues will be identified and referred to the Care Improvement Committee or the Quality Improvement and Patient Safety Committee for consideration of remedial action with the assistance of the Quality Improvement and Patient Safety Department. Such referrals will be tracked by the Committee until resolved.

In addition, The Committee will receive at least semi-annual reports regarding behavioral complaints (in addition to the PARS reports). These will include groupings of complaints by physician, service, patient care unit, etc., so that trends can be noted and expanded monitoring or interventions can be instituted as indicated.

Interventions may include educational programs for the entire Medical Staff, training of leaders dealing with professional behavior concerns, clinical team development, or clinical process changes that foster collegial, professional interactions among other health professionals and staff.

**VI. ENFORCEMENT**

When the Medical Staff member does not agree to the recommendations of the Committee, the case will be referred to the Care Improvement Committee or directly to the Medical Executive Committee depending on the specifics of the concerns and recommendations. This decision will be made by the Chief of Staff with the advice of the Committee.

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Any remedial or disciplinary actions imposed against the will of the Medical Staff member must ultimately be decided on by the Medical Executive Committee and the member will have recourse to the fair hearing process described in the Medical Staff Bylaws.

## **VII. ROLE OF THE WELLBEING COMMITTEE**

The Wellbeing Committee functions as a resource, and in many cases an advocate, for Medical Staff members who are attempting to cope with challenges posed by a variety of impairments, including mental illness, substance abuse, or personality and behavior issues.

The Wellbeing Committee is not a disciplinary body. Medical Staff members may avail themselves of its assistance in order to avoid disciplinary action by the Medical Staff, but involvement of the Wellbeing Committee does not immunize members from disciplinary consequences of any subsequent misbehavior.

In certain instances, the Wellbeing Committee may also serve as a monitoring body, such as in cases of substance abuse, so that members can continue to practice medicine safely without significant risk to patients.

## **VIII. REPORTING AND OVERSIGHT**

The Committee is an ad hoc subcommittee of the Medical Executive Committee, and will report to the Medical Executive Committee at least semi-annually. This report will include information as to the number of referrals from both the PARS program and from other sources, a summary of the disposition of the referrals, and a summary of systems issues identified and their resolution.

## **IX. RELATED DOCUMENTS**

- *Development of an Early Identification and Response Model of Malpractice Prevention*, published in Law and Contemporary Problems, Vol. 60, No. 1, Winter 1997.
- Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and

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addressing unprofessional behaviors. Acad Med. 2007 Nov;82(11):1040-8.

- Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J, Bost P. Patient complaints and malpractice risk. JAMA. 2002 Jun 12;287(22):2951-7.
- SHC Medical Staff Bylaws, 6.1. Basis of Review
- SHC Medical Staff Bylaws, 12.3 Special Committees
- Medical Staff Code of Professional Behavior Policy

## **X. DOCUMENT INFORMATION**

- A. Legal Authority/References
  - 1.
  - 2.
- B. Author/Original Date  
Debra Green/January 2010
- C. Gatekeeper of Original Document  
Administrative Manual Coordinators and Editors
- D. Distribution and Training Requirements
  1. This policy resides in the Administrative Manual of Stanford Hospital and Clinics.
  2. New documents or any revised documents will be distributed to Administrative Manual holders. The department/unit/clinic manager will be responsible for communicating this information to the applicable staff.
- E. Review and Renewal Requirements  
This policy will be reviewed and/or revised every three years or as required by change of law or practice.
- F. Review and Revision History

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This is a new policy.

- G. Approvals
  - SHC Medical Executive Committee February 2010
  - SHC Board Credentials, Policies and Procedures Committee, February 2010

***LAST ON DOCUMENT:***

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