UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-MS0006*
INDEX TITLE: Medical Staff

SUBJECT: Medical Staff Professionalism Policy of UPMC
DATE: April 1, 2024

This Policy applies to the following United States based UPMC facilities, including any providers who practice therein:

[Check all that apply]

☒ UPMC Children's Hospital of Pittsburgh	☒ UPMC Pinnacle Hospitals
☒ UPMC Magee-Womens Hospital	☒ Harrisburg Campus
☒ UPMC Altoona	☒ West Shore Campus
☒ UPMC Bedford	☒ Community Osteopathic Campus
☒ UPMC Chautauqua	☒ UPMC Carlisle
☒ UPMC East	☒ UPMC Memorial
☒ UPMC Hamot	☒ UPMC Lititz
☒ UPMC Horizon	☒ UPMC Hanover
☒ Shenango Campus	☒ UPMC Muncy
☒ Greenville Campus	☒ UPMC Wellsboro
☒ UPMC Jameson	☒ UPMC Williamsport
☒ UPMC Kane	☒ Williamsport Campus
☒ UPMC McKeesport	☒ Divine Providence Campus
☒ UPMC Mercy	☒ UPMC Cole
☒ UPMC Northwest	☒ UPMC Somerset
☒ UPMC Passavant	☒ UPMC Western Maryland
☒ Main Campus	
☒ Cranberry	
☒ UPMC Presbyterian Shadyside	
☒ Presbyterian Campus	
☒ Shadyside Campus	
☒ UPMC Western Psychiatric Hospital	
☒ UPMC St. Margaret	

Provider-based Ambulatory Surgery Centers

☒ UPMC Altoona Surgery Center
☒ UPMC Children's Hospital of Pittsburgh North
☒ UPMC St. Margaret Harmar Surgery Center
☒ UPMC South Surgery Center
☒ UPMC Center for Reproductive Endocrinology and Infertility

Free-Standing Ambulatory Surgery Facilities:

☐ UPMC Hamot Surgery Center **(JV)**
☐ Hanover SurgiCenter
☐ UPMC Specialty Care York Endoscopy
☐ Susquehanna Valley Surgery Center
☐ West Shore Surgery Center **(JV)**

☒ UPMC Digestive Health and Endoscopy Center
☒ UPMC Surgery Center – Carlisle
☒ UPMC Surgery Center Lewisburg
☒ UPMC Pinnacle Procedure Center
☒ UPMC West Mifflin Ambulatory Surgery Center
☒ UPMC Community Surgery Center
☒ UPMC Leader Surgery Center

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1. POLICY

(a) Collegiality, collaboration, and professionalism are essential for the provision of safe and competent patient care. Inappropriate Conduct (as defined in Appendix A) is inconsistent with a culture of quality care and safety. Accordingly, all Practitioners at the Participating UPMC Hospital (the "Hospital") must treat others with respect, courtesy, and dignity, and must conduct themselves in a professional and cooperative manner.

(b) This Policy outlines the process that will be used to evaluate and collegially resolve concerns that a Practitioner has engaged in Inappropriate Conduct. A flowchart that outlines the review process is in Appendix B.

2. REPORTS OF INAPPROPRIATE CONDUCT

2.A ***Reports.***

(1) Hospital employees or Practitioners who believe they have observed, or been subjected to, Inappropriate Conduct by a Practitioner shall report the incident in a timely manner. Any individual receiving such a report will forward it to the PPE Specialists Committee.

(2) Anyone who receives a report of conduct that may be criminal in nature should bring the concern to the attention of security personnel and/or law enforcement, in addition to Hospital leadership.

2.B ***Notifications.***

(1) The PPE Specialists Committee will notify the Medical Staff President, relevant Department Chair and Vice President of Medical Affairs ("VPMA") of all reported concerns and log them in a confidential peer review database.

(2) If a report involves an allegation of Sexual Harassment or Other Identity-Based Harassment, the Hospital's Human Resources department will also be notified.

2.C ***Follow-up with Individual Who Filed Report.*** The PPE Specialists Committee will follow up with individuals who file a report. A Response to Individual Who Reported Concerns About Conduct is included in the Professionalism Manual.

3. RESOLUTION OF MINOR CONCERNS

3.A ***Criteria for Resolution of Minor Concerns.*** A reported concern may be resolved without the need for further review under this Policy if the Medical Staff President or the Department Chair, in conjunction with the VPMA, acting on the behalf of the Leadership Council, determine that: (1) the reported concern is minor in nature; and (2) there is no history or pattern with the Practitioner in question. Any reported concern involving allegations of Sexual Harassment or Other Identity-Based Harassment will generally ***not*** be reviewed as a minor concern under this Section 3. (See Section 9 of this Policy.)

3.B ***Procedure for Resolution of Minor Concerns.***

(1) For concerns that qualify as minor, the Medical Staff President, Department Chair or VPMA, acting on the behalf of the Leadership Council, will communicate with the Practitioner about the matter (e.g., via a brief conversation or note). The purpose of this communication is to make the Practitioner aware that another individual perceived the Practitioner's behavior as inappropriate so that the Practitioner may reflect and self-correct as needed. No conclusions about the Practitioner's behavior are reached as a result of this process, so there is no need for fact-finding or input from the Practitioner. The individual who communicates with the Practitioner may choose to follow up with a brief note to the Practitioner memorializing any conversation.

(2) The Medical Staff President or VPMA will notify the PPE Specialists Committee that a minor concern has been resolved in this manner. A Form to Document Resolution of Minor Concerns is included in the Professionalism Manual.

3.C ***Reports to Leadership Council.*** The PPE Specialists Committee will provide the Leadership Council with aggregate data of minor concerns that have been resolved under this section to allow for oversight of the process and consistency.

4. PROCEDURE WHEN CONCERNS ARE MORE SIGNIFICANT OR A PATTERN HAS DEVELOPED

The steps set forth below apply to reported concerns about behavior that, as determined by the Medical Staff President or Department Chair, in conjunction with the VPMA, acting on the behalf of the Leadership Council, involve: (1) more serious allegations; or (2) a pattern of behavior. All allegations of Sexual Harassment or Other Identity-Based Harassment will be reviewed pursuant to this Section 4.

4.A ***Preliminary Notification to Practitioner.*** On behalf of the Leadership Council, the Medical Staff President, Department Chair, or VPMA should notify the Practitioner that a concern has been raised and that the matter is being reviewed. Generally,

this preliminary communication should occur via a brief telephone call or a personal discussion as soon as practical. The Practitioner should be informed that he or she will be invited to provide input regarding the matter after further review of the reported concern has occurred and before any review by the Leadership Council. 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). The Professionalism Manual includes an Instructions and Script and a Form to Document Preliminary Notification to Practitioner When Concerns Are More Significant or a Pattern Has Developed.

4.B ***Notification to Employer.*** In accordance with the Policy on Sharing Peer Review Information Among UPMC Entities, if a reported concern involves an Employed Practitioner (as defined in this Policy), the PPE Specialists Committee will notify the Employer that the matter is being reviewed. The Employer will be invited to provide any information that it believes may be relevant to the Employed Practitioner and the concern being reviewed. The Employer will also be informed that the Leadership Council may request the Employer's participation in the review.

4.C ***Fact-Finding.***

(1) On behalf of the Leadership Council, the PPE Specialists Committee, Medical Staff President, Department Chair and/or VPMA will, as needed, conduct or direct the fact-finding needed to assess the reported concern (for example, by interviewing witnesses or others who were involved in the incident and reviewing documentation). An Interview Tool for Fact-Finding: Script, Questions and Guidance is included in the Professionalism Manual.

(2) The Hospital's Human Resources department will be notified of any allegation of Sexual Harassment or other Identity-Based Harassment by a Practitioner. A representative(s) of the Hospital's Human Resources department may participate in fact-finding and attend portions of meetings of the Leadership Council at which the matter is discussed.

4.D ***Determination on Behalf of the Leadership Council, by the Medical Staff President/Department Chair and VPMA.***

(1) ***No Further Review Required.*** Following the interviews and fact-finding, the Medical Staff President or Department Chair, in conjunction with the VPMA, acting on behalf of the Leadership Council, may determine that a reported concern does not raise issues that need to be addressed pursuant to this Policy. In such case, no input regarding the circumstances will be sought from the Practitioner and the matter will be closed. The Practitioner and Leadership Council will be notified of this determination and documentation that the matter was closed will be maintained.

(2) ***Further Review Required.*** The Medical Staff President or Department Chair, in conjunction with the VPMA, acting on behalf of the Leadership Council, may determine that a matter should be reviewed further by the Leadership Council. In such case, the Practitioner's input will be obtained as set forth in Section 5 of this Policy.

5. OBTAINING INPUT FROM THE PRACTITIONER

5.A ***General.*** The Leadership Council (or the Medical Staff President or Department Chair, in conjunction with the VPMA as its designee) will provide details of the concern (but not a copy of any reported concern) to the Practitioner and ask the Practitioner to provide a written response. A Cover Letter to Practitioner Seeking Input Regarding Behavior Concern which may be used for this purpose is included in the Professionalism Manual.

5.B ***Sharing Identity of Any Individual Reporting a Concern.*** Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter will not be disclosed to the Practitioner unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.

5.C ***Reminder of Practitioner's Obligations.*** The Leadership Council (or the Medical Staff President or Department Chair, in conjunction with the VPMA as its designee) should remind the Practitioner of the need to maintain confidentiality and the importance of avoiding any actions that could be viewed as retaliation as part of seeking his or her input. The Cover Letter to Practitioner Seeking Input Regarding Behavior Concern set forth in the Professionalism Manual addresses these issues.

5.D ***Failure of the Practitioner to Provide Requested Input or Attend Meeting.***

(1) ***Automatic Relinquishment for Failure to Provide Written Input or Attend Meeting.*** A Practitioner's failure to provide written input or attend a meeting when requested to do so pursuant to this Policy will result in the automatic relinquishment of the Practitioner's clinical privileges, but only if all of the following conditions are satisfied:

(a) the Practitioner is asked in writing to provide written input to, or attend a meeting with, the Leadership Council (or the Medical Staff President or Department Chair, in conjunction with the VPMA as its designee); and

(b) the written request gives the Practitioner a reasonable amount of time (generally five days) to provide the written input or to prepare for the meeting; and

(c) the written request notifies the Practitioner that failure to provide the written input or attend the meeting will result in the automatic relinquishment of clinical privileges pursuant to this Policy.

The Cover Letter to Practitioner Seeking Input Regarding Behavior Concern set forth in the Professionalism Manual satisfies these requirements. A Notice of Automatic Relinquishment that may be used if a Practitioner does not provide the requested input or attend a meeting is included in the Professionalism Manual.

(2) ***When Temporary Automatic Relinquishment Becomes Automatic Resignation from Staff.*** If a Practitioner automatically relinquishes clinical privileges pursuant to this Policy and fails to provide the requested written input or meet with the applicable individuals or committee 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.

(3) ***Automatic Relinquishment and Automatic Resignation Not Reportable.*** 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. LEADERSHIP COUNCIL PROCEDURE

6.A ***Initial Review.*** The Leadership Council shall review all supporting documentation, including the response from the Practitioner. The Leadership Council may also meet with the individual who submitted the report and any witnesses to the incident. The Leadership Council may consult with or include in the review the Department Chair, another Medical Staff Leader, a representative of the Employer, or any other individual who would be helpful to the review.

6.B ***Meeting Between Practitioner and Leadership Council.*** If either the Leadership Council or the Practitioner believes that it would be helpful prior to the Leadership Council concluding its review, a meeting may be held between the Practitioner and the Leadership Council to obtain more facts. In its discretion, the Leadership Council 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 as set forth in Section 5 of this Policy.

6.C ***Refusal to Provide Information or Meet with Leadership Council.*** A Practitioner who refuses to provide information or meet with the Leadership Council will be

deemed to have automatically relinquished his or her clinical privileges as set forth in Section 5 of this Policy.

6.D ***Employer Participation in Review.*** If a matter involves an Employed Practitioner, the Leadership Council may invite a representative of the Employer to attend relevant portions of committee meetings involving the Practitioner and participate in any interventions that may be conducted by the Leadership Council following the review. The chair of the Leadership Council has the discretion to recuse the Employer representative during any deliberations or vote on a matter.

6.E ***Leadership Council Determination.*** The Leadership Council may:

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

(2) send the Practitioner an Educational Letter;

(3) engage in Collegial Counseling;

(4) develop a Performance Improvement Plan for Conduct ("PIP"), as described in Section 7 of this Policy;

(5) refer the matter to the Medical Executive Committee; or

(6) after consultation with the Employer, refer the matter to the Employer for disposition, with a report back to the Leadership Council regarding the action taken by the Employer. If the Leadership Council determines the Employer's action is insufficient, the Leadership Council may also make one of the other determinations set forth in this subsection.

6.F ***Leadership Council Review Not an Investigation.*** A review conducted by the Leadership Council or by any individual pursuant to this Policy shall not constitute an Investigation. The Leadership Council possesses no disciplinary authority and only the Medical Executive Committee has the authority to commence a formal Investigation under the Medical Staff Bylaws.

6.G ***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 successfully resolve the concerns.

7. PERFORMANCE IMPROVEMENT PLANS FOR CONDUCT

7.A ***General.*** The Leadership Council may determine it is necessary to develop a Performance Improvement Plan ("PIP") for the Practitioner. 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.

7.B ***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 a recommended PIP developed by the Leadership Council, the Practitioner is under no obligation to participate in it. 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 pursuant to the Medical Staff Bylaws.

7.C ***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 Medical Staff Bylaws, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank. A Performance Improvement Plan ("PIP") Options for Conduct – Implementation Issues Checklist that may be used to assist with implementation of the following PIP options is included in the Professionalism Manual.

(1) ***Education/CME*** which means that, within a specified period of time, the Practitioner must arrange for education or CME related to behavioral matters of a duration and type approved by the Leadership Council. Such education or CME might address, for example, how to improve communications with patients or other health care professionals, how to better function as part of a health care team, or the effect of behavior on patient safety. The cost of such education or CME will be paid by the Practitioner, unless the Leadership Council determines otherwise;

(2) ***Meeting with Designated Group to Conduct Enhanced Collegial Counseling.*** The Practitioner may be invited to meet with a designated committee or an ad hoc group to discuss the concerns with the Practitioner's conduct and the need to modify the conduct. Such 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. A letter outlining the discussion and expectations for conduct will be sent to the Practitioner after the meeting;

(3) ***Periodic Meetings with Medical Staff Leaders or Mentors.*** The Leadership Council may recommend that the Practitioner 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;

(4) ***Review of Literature Concerning the Connection Between Behavior and Patient Safety.*** The Leadership Council may recommend that the Practitioner 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;

(5) ***Behavior Modification Course.*** The Leadership Council may recommend that the Practitioner complete a behavior modification course that is acceptable to the Leadership Council. The cost of this external assistance will be paid by the Practitioner, unless the Leadership Council determines otherwise;

(6) ***Personal Code of Conduct.*** The Leadership Council may develop a "personal" code of conduct for the Practitioner, which provides specific guidance regarding the expectations for future conduct and outlines the specific consequences of the Practitioner's failure to abide by it; and/or

(7) ***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 Practitioners to improve their performance and to protect patients and staff.

8. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

8.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.

8.B ***Medical Executive Committee Review.*** The Medical Executive Committee shall review the matter in accordance with the Credentials Policy.

9. REVIEW OF REPORTS OF SEXUAL HARASSMENT AND OTHER IDENTITY-BASED HARASSMENT

9.A ***Definition.*** Sexual Harassment and other Identity-Based Harassment is defined in Appendix B.

9.B ***Review Process.*** All reports of potential Sexual and Other Identity-Based Harassment will be referred to the Hospital's Human Resources department for its review. Representatives from the Leadership Council may be invited to participate in the review process. In addition, a Practitioner may be asked to voluntarily refrain from exercising clinical privileges pending the review of any such reported concern. Such a referral to Human Resources shall not preclude the Medical Executive Committee from taking other action under the Medical Staff Bylaws or Credentials Policy.

10. ADDITIONAL PROVISIONS GOVERNING THE PROFESSIONALISM REVIEW PROCESS

10.A ***Confidentiality.*** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

(1) ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents (whether paper or electronic) should be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under state or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

(2) ***Verbal Communications.*** Telephone and in-person conversations should take place in private at appropriate times and locations to minimize the risk of a breach of confidentiality (e.g., conversations should not be held in Hospital hallways).

(3) ***E-mail.*** Hospital e-mail may be used to communicate between individuals participating in the professional practice evaluation process, including with those reviewing a case and with the Practitioner whose care is being reviewed. All e-mails should include a standard convention, such as "Secure: Confidential PPE/Peer Review Communication" in the subject line. All participants in the PPE process are strongly encouraged to use their Hospital e-mail accounts to maximize peer review and HIPAA privacy protections. E-mail may also be sent to non-Hospital accounts when: (i) the e-mail merely directs recipients to check their Hospital e-mail, or (ii) the e-mail is encrypted in a manner approved by Hospital policy. Any e-mail

containing a patient's protected health information must comply with the Hospital's HIPAA policies.

(4) ***Participants in the Review Process.*** All individuals involved in the review process (Medical Staff and Hospital employees) must maintain the confidentiality of all information generated during a review. All such individuals should sign a Confidentiality Agreement (see the Professionalism Manual for examples).

(5) ***Practitioner Under Review.*** The Practitioner under review must maintain all information related to the review in a strictly confidential manner. 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 Hospital, except for any legal counsel who may be advising the Practitioner.

10.B ***False Reports.*** Intentionally false reports will be grounds for disciplinary action. False reports by Practitioners will be reviewed under this Policy. False reports by Hospital employees will be referred to the Hospital's Human Resources department.

10.C ***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 this Policy.

10.D ***Coordination with Other Policies That Govern Professional Conduct.*** If a report of Inappropriate Conduct 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 Medical Staff President or VPMA 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 the Professionalism Policy or may discuss the matter with the Leadership Council or its representatives.

10.E ***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. In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

(2) Practitioners may not create an audio or video recording of a meeting. If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, Medical Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room. Medical Staff Leaders or Hospital personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

10.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 is free to respond in writing, and the Practitioner's response shall also be kept in the Practitioner's confidential file.

10.G ***When Both Clinical and Behavioral Concerns Are at Issue.*** If a matter involves both clinical and behavioral concerns, the Chairs of the Leadership Council and Professional Practice Evaluation Committee ("PPEC") should coordinate the reviews. The behavioral concerns may either be:

(1) addressed by the Leadership Council pursuant to the Professionalism Policy, with a report to the PPEC; or

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

10.H ***Supervising Physicians and Advanced Practice Professionals or Allied Health Professionals.*** Except as noted below, a physician who has a supervisory or collaborative relationship with an Advanced Practice Professional or Allied Health Professional for state licensure purposes shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving the Advanced Practice Professional or Allied Health Professional. Without limiting the foregoing, the primary supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional or Allied Health Professional is sent under this

Policy and may be invited to participate in any meetings or interventions. The primary supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the primary supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

10.I ***Delegation of Functions.***

(1) The Leadership Council is responsible for the professionalism/quality assurance process described in this Policy, subject to the oversight of the Medical Executive Committee and Board. To promote a prompt and effective review process, the Leadership Council hereby expressly delegates to the PPE Specialists Committee, Medical Staff Leaders, and the VPMA the authority to perform the functions described in this Policy on behalf of the Leadership Council. Actions taken by these individuals will be reported to and reviewed by the Leadership Council as set forth in this Policy.

(2) When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of Hospital management, by a Medical Staff member, 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. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(3) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

10.J ***Professionalism Manual.*** Forms, checklists, template letters and other documents that assist with the implementation of this Policy are collectively known as the Professionalism Manual. Such documents will be developed and maintained by the PPE Specialists Committee. Individuals performing a function pursuant to this Policy should use the document currently approved for that function and revise as necessary. However, failure to use such a document does not affect the validity of a review.

10.K ***Substantial Compliance.*** While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

10.L ***Reports to Medical Executive Committee, Practitioners and Board.*** The Leadership Council should periodically prepare reports that provide aggregate information regarding the professionalism review process (e.g., numbers of concerns reviewed by department or specialty; the types of dispositions for those concerns; etc.). These reports may be disseminated to the Medical Executive Committee, all Practitioners at the Hospital, and the Board for the purposes of reinforcing the primary objectives outlined in Section 1 of this Policy and permitting appropriate oversight. A sample Summary Report for Professionalism Review Activities to Be Provided to All Practitioners, MEC, and Board is included in the Professionalism Manual.

10.M ***Agreement to Voluntarily Refrain from Exercising Clinical Privileges or Other Practice Conditions.***

(1) At any point in the review process described in this Policy, the Leadership Council or its representatives may ask a Practitioner to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, Medical Staff Leaders and the Practitioner may also agree upon practice conditions that will protect the Practitioner, patients, and staff during the review process. Prior to any such action, the Practitioner shall be given the opportunity to discuss these issues with the Leadership Council or its representatives.

(2) These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or final finding of responsibility for the concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

10.N ***Definitions.*** Unless otherwise indicated below, the terms used in this Policy are defined in the Medical Staff Credentials Policy.

(1) ***"Employed Practitioner"*** means a Practitioner who is employed by an Employer.

(2) ***"Employer"*** means:

(a) the Hospital; or

(b) a UPMC-related entity or a private entity that:

(i) has a formal peer review process and an established peer review committee; and

(ii) is subject to the same information sharing policy as the Hospital, or has information sharing provisions in a professional services contract or in a separate information sharing agreement with the Hospital.

(3) ***"Inappropriate Conduct"*** means the conduct defined in Appendix A.

(4) ***"PPE Specialists Committee"*** means a member of the PPE Specialists Committee at a Participating UPMC Hospital. This may include, but is not limited to, a Quality Department RN Reviewer, VPMA, applicable Department Chair, representatives from Medical Staff Services, and/or representatives of the Wolff Center who work on behalf of the Participating UPMC Hospital.

(5) ***"Sexual Harassment and Other Identity-Based Harassment"*** means the conduct defined in Appendix B.

11. AMENDMENTS

(a) The Medical Staffs and Board at each Participating UPMC Hospital have independently adopted this Policy as their own by voting to approve it for use at each of their respective facilities. In doing so, the Participating UPMC Hospitals have delegated to the Medical Review Council the authority to develop and adopt amendments to this Policy.

(b) Notice of any amendments will be provided to the Medical Executive Committees at each Participating UPMC Hospital for their information. Any amendments to this Policy will take effect immediately upon receiving notice of the changes from the Medical Review Council.

(c) If any Medical Executive Committee has concerns about an amendment, they may bring the concern to the attention of the Medical Review Council. The Medical Executive Committee may also recommend to its Board that the Hospital opt out of this Policy and reestablish its own.

APPENDIX A

DEFINITION OF INAPPROPRIATE CONDUCT AND SEXUAL HARASSMENT/OTHER IDENTITY-BASED HARASSMENT

1. ***"Inappropriate Conduct"*** means behavior that, as determined by the Leadership Council, adversely affects the healthcare team's ability to work effectively and/or has a negative effect on the communication and collaboration necessary for quality and safe patient care. To aid in both the education of Practitioners and the enforcement of this Policy, ***"Inappropriate Conduct"*** includes, but is not limited to:

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

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

   (c) refusal or failure to answer questions, or return phone calls or pages in a timely manner as defined in the Medical Staff Bylaws documents or other applicable policies;

   (d) intentional misrepresentation to Hospital administration, Professional Staff Leaders, other Practitioners, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken, or filing an intentionally false report about another individual pursuant to this Policy, the Professional Practice Evaluation Policy, or another Hospital or Medical Staff Policy;

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

   (f) retaliating against any individual who may have reported a quality 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, approach and 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) unprofessional 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 maintain and renew in a timely manner all credentials required by the Medical Staff Bylaws;

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

(k) unprofessional 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) 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);

(m) 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;

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

(o) unprofessional access, use, disclosure, or release of confidential patient information;

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

(q) use of social media in a manner that involves Inappropriate Conduct as defined in this Policy or other Medical Staff or Hospital policies;

(r) disruption of hospital operations, hospital or Medical Staff committees, or departmental affairs;

(s) refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, 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);

(t) conduct that is inconsistent with the ethical obligations of health care professionals; and/or

(u) engaging in ***Sexual Harassment or other Identity-Based Harassment*** as defined in Section 2 of this Appendix.

ADDITIONAL NOTE REGARDING INAPPROPRIATE CONDUCT:

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

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

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

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

2. ***Sexual Harassment and Other Identity-Based Harassment*** are a form of ***Inappropriate Conduct***, and include verbal or physical conduct that:

(a) is unwelcome and offensive to an individual who is subjected to it or who witnesses it;

(b) could be considered harassment from the objective standpoint of a "reasonable person"; and

(c) is covered by state or federal laws governing discrimination. This includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination.

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 ***not*** dispositive in determining whether conduct is Sexual Harassment or Other Identity-Based Harassment 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 by Practitioners than the minimum required by federal or state law.

Sexual Harassment and Other Identity-Based Harassment include all of the following behaviors:

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

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

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

- ***Quid Pro Quo:*** suggesting that submission to a sexual advance will lead to a positive employment action or avoid a negative employment action; and

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

SIGNED: Donald M. Yealy, MD
Senior Vice President, UPMC and Chief Medical Officer, UPMC Health Services
ORIGINAL: April 1, 2024
APPROVALS:
Policy Review Subcommittee: March 13, 2024
Executive Staff: March 29, 2024 (effective April 1, 2024)
PRECEDE:
SPONSOR: UPMC Medical Staff Services

*** With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

UPMC HOSPITALS

Appendix B: Review Process for Concerns Regarding Professional Conduct

Reported concern regarding professional conduct*

Document, Follow-Up, and Initial Triage

PPE Specialists Committee:

1. Document referral
2. Follow up with individual who reported concern, as necessary

On behalf of the Leadership Council, the Medical Staff President or Department Chair, with VPMA:

3. Determine if the matter should be ***closed***, referred for ***informal resolution***, or if the matter is ***more significant or there is a pattern of concern*** that requires additional review

Minor Concern Requiring Informal Resolution

- Concern is minor ***and*** there is no pattern of behavior
- There is no need to conduct additional fact-finding regarding event or need for Practitioner to respond to concern
- On behalf of the Leadership Council, the Medical Staff President, Department Chair, or VPMA communicates with Practitioner about matter (e.g., via brief conversation or note to Practitioner)
- PPE Specialists Committee report aggregate data to Leadership Council to permit oversight

Significant Concerns/ Pattern of Behavior

- Concern is more significant ***or*** a pattern exists
- Provide ***preliminary notification*** of concern to Practitioner
- Notify Employer, if applicable *(see **Note 1**)*
- Conduct ***additional fact-finding*** (e.g., interviews with witnesses and others)
- On behalf of the Leadership Council, the Medical Staff President/Department Chair and VPMA then decide either:
  - (1) ***Further review required.*** Obtain input from Practitioner then prepare summary for review by Leadership Council
  - (2) ***No further review required.*** Close matter and notify Practitioner and Leadership Council (to allow for oversight of process and consistency)

Leadership Council

General Conduct Concern

1. Review summary report and all supporting documentation
2. Consult with or include Department Chair and/or representative of Employer *(see **Note 1**)*, if helpful in resolving concern
3. Meet with individuals involved and witnesses, if necessary
4. Meet with Practitioner, if necessary or if requested by Practitioner
5. ***Determination***
   - A. Close case if no further review is required
   - B. Send Educational Letter
   - C. Conduct Collegial Counseling
   - D. Develop Performance Improvement Plan ("PIP") for Conduct
   - E. Refer to Employer for disposition, after consultation with Employer (with a report back to Leadership Council of final action taken by Employer)
   - F. Refer to MEC

Sexual Harassment and Other Identity-Based Harassment

(e.g., based on gender, race, religion, etc.)

1. If there is a single confirmed incident:
   - A. Practitioner must agree there will be no similar conduct in the future, and
   - B. Letter of warning, Collegial Counseling, or PIP for Conduct, as appropriate.
2. If Practitioner does not acknowledge concern or seriousness, or there are additional incidents of Sexual Harassment or Identity-Based Harassment, refer to MEC

As needed →

MEC

Review under Medical Staff Credentials Policy if: individual refuses to cooperate with Leadership Council, PIP for Conduct was unsuccessful, or Leadership Council determines MEC review is required

Note 1:

An "Employer" is:

(1) the Hospital; or

(2) a UPMC-related entity or a private entity that:

(a) has a formal peer review process and an established peer review committee; ***and***

(b) is subject to the same information sharing policy as the Hospital, or has information sharing provisions in a professional services contract or in a separate information sharing agreement with the Hospital.

* Anyone who receives a report of conduct that may be criminal in nature should bring the concern to the attention of security and/or law enforcement, if appropriate, in addition to hospital leadership.